

Focus on health

**minority
rights
group
international**

**State of the
World's Minorities
and Indigenous
Peoples 2013**

Events of 2012



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the World's
Minorities
and Indigenous
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Front cover: A Dalit woman who works as a Community Public Health Promoter in Nepal. *Jane Beesley/Oxfam GB.*

Inside front cover: Indigenous patient and doctor at Klinik Kalvary, a community health clinic in Papua, Indonesia. *Klinik Kalvary.*

Inside back cover: Roma child at a community centre in Slovakia. *Bjoern Steinz/Panos*

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Minority Rights Group International
54 Commercial Street, London E1 6LT,
United Kingdom.
Tel: +44 (0)20 7422 4200
Fax: +44 (0)20 7422 4201
Email: minority.rights@mrgmail.org
Website: www.minorityrights.org

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Edited by Beth Walker

Minority Rights Group International

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Foreword

Paul Hunt, UN Special Rapporteur
on the right to health (2002–2008)

We live in a world of profound health inequalities, a world in which a person's health and the quality of care they receive is determined by their ethnicity, the language they speak or their religious and cultural beliefs.

In almost every country in the world, minorities and indigenous peoples are among the poorest and most vulnerable groups, suffer greater ill-health and receive poorer quality of care than other segments of the population.

They die younger, suffer from higher rates of disease and struggle more to access health services

compared to the rest of the population.

More often than not, this ill-health and poor healthcare is a symptom of poverty and discrimination.

In sub-Saharan Africa, a young Samburu woman dies from complications during childbirth because the government does not provide any medical care in the area where she lives. In Rwanda, a Batwa child suffers from debilitating but easily treatable intestine worms because of the dirty water he drinks. In India, health

Below: A Batwa child in Rwanda. *Eric Lafforgue.*



workers refuse to visit a Dalit village because of untouchability practices. The suicide rate among Yazidis living in Sinjar, Iraq, has escalated because of their desperate situation.

The early mortality and greater morbidity faced by so many minorities and indigenous peoples is a matter of pressing social justice for which governments and other actors must be held accountable.

The right to health – the right to survive – is the most basic human right; its fulfilment is both a precondition to, and a by-product of, the enjoyment of all other rights. But health is also a right in itself under international law and in the constitutions of many countries.

The international right to health – or the right of everyone to the highest attainable standard of physical and mental health – not only includes access to medical care, but also to the underlying determinants of health, such as safe water, adequate sanitation, decent housing, healthy working conditions, a clean environment, health-related information (including on sexual and reproductive health) and freedom from discrimination. The right has a pre-occupation with disadvantaged groups, participation and accountability. It demands that health-related services be evidence-based, respectful of cultural difference and of good quality. Moreover, it places a responsibility on high-income countries to help other countries deliver the right to health to everyone within their borders.

And so ensuring minority and indigenous peoples can live healthy lives is not just a question of providing vaccines or treating particular diseases, it requires us to address the underlying causes of ill-health.

This is why as UN Special Rapporteur on the right to health I focused on two critical barriers to access to health and well-being: poverty and discrimination. Through a right-to-health ‘lens’, I looked at a range of issues, including access to medicines, water and sanitation, mental health, the Millennium Development Goals (MDGs), sexual and reproductive health, the work of international financial institutions, accountability, and

so on. I argued, for example, that reducing maternal mortality is not just an issue of development, but also an issue of human rights. But despite longstanding international commitments to reducing maternal mortality, so far progress has been disappointing for many minority and indigenous women, as numerous examples in this volume demonstrate.

Although the MDGs underscore the critical importance of health, government initiatives often fail to reach those most in need. National-level targets allow governments and the international community to ignore persistent inequalities. Stretched resources lead governments and donors to focus on easy-to-reach population groups. Too often language barriers or different cultural and religious practices are not taken into account when designing health interventions.

New strategies are now needed to ensure the right to health for minorities and indigenous peoples in both the global North and global South.

I welcome this edition of Minority Rights Group’s annual report, which will build a better understanding among readers about the health issues facing minority and indigenous communities and what can be done to address their needs.

It not only provides us with a better understanding of the state of health for minorities and indigenous peoples, it also raises neglected but important issues that affect indigenous and minority health. These include the link between land security, displacement and health; the social exclusion and lack of political power that prevent groups from achieving better care; the need for culturally sensitive care; and the importance of traditional medicine.

This volume also suggests constructive ways forward. It highlights the importance of collecting health data about specific ethnic, religious and linguistic groups to ensure no one is left behind. It provides compelling evidence of the positive impact of involving minorities and indigenous peoples in designing health interventions and broader political processes. It also

provides examples of targeted measures to tackle discrimination – such as collecting evidence, supporting access to justice, training health professionals and providing culturally adapted health services. Many organizations do outstanding work to improve health outcomes for vulnerable people. In India, participatory women’s groups and community monitoring of health outcomes have radically reduced maternal deaths and newborn mortality among eastern India’s Adivasi communities. In eastern Europe, training Roma to act as health mediators has increased vaccination rates among Roma and helped community members access medical treatment. In Namibia, San have worked with non-governmental organizations to design mobile clinics to treat multi-drug resistant tuberculosis in nomadic communities. In Peru, traditional birthing practices have been integrated in the mainstream health system, encouraging indigenous women to give birth in hospitals, reducing preventable deaths. In the Mekong region of South East Asia, local radio dramas have raised awareness about HIV and available treatment among ethnic minority groups.

All these examples show human rights for minorities and indigenous peoples, coupled with a human rights-based approach to development, can strengthen any new global development strategy – both in the global North and the global South.

I strongly recommend this excellent book to governments, health professionals, human rights advocates, aid agencies, and minority and indigenous groups – and everyone committed to deepening social justice, health and human rights. ■

Addressing health inequalities in the post-2015 development framework¹

Corinne Lennox



Above: A community health worker examines a Dalit child, India. *Dalit Freedom Network.*

In a village in Gujarat, India, most of the Dalits seeking health services have to wait longer for their turn because the dominant caste people are given priority. Only where the doctor is also a Dalit are they given equal priority in appointments. Health workers rarely visit the Dalit quarters of the village. In the health care centre, Dalits do not sit on the benches provided and they drink water from separate vessels kept for them. ‘Untouchability’ is widely practised in the delivery of health services.² Across India, these realities have meant that Dalits have disproportionately high rates of mortality and diseases compared with most of their fellow citizens.

This is one picture of discrimination in access to health that is faced by minorities and indigenous peoples across the globe. There is wide agreement that tackling inequality needs to be central to the post-2015 development framework that will replace the Millennium Development Goals (MDGs) in two years’ time. Not only is such an approach fair and just, it also makes good development sense. Inequality

has been shown to hamper poverty reduction and growth strategies, to create tensions and conflict between communities, and to undermine democratic governance.

This increased focus on inequality has given an important voice to minorities and indigenous peoples, who have long experienced the negative effects of inequality. A major cause of this inequality is the violation of the human rights of minorities and indigenous peoples, and national policies that do not reflect their own priorities or perceptions of development.

This chapter will show how specific attention to human rights for minorities and indigenous peoples, coupled with a human rights-based approach to development, can strengthen any new global development strategy on access to health. As the evidence will suggest, strategies for these groups are needed in both the global North and South.

Assessing the impact of the MDGs

Over the past three years, a major consultation process has been under way to devise a new global development plan for the post-2015 era when the MDGs will conclude. This consultation has involved civil society, states and independent experts, principally guided by UN institutions. In September 2013, the UN General Assembly will meet to discuss the recommendations from this process and to begin planning a new framework to follow the MDGs.

Civil society groups have been involved primarily in a series of thematic consultations organized by the UN. This has been complemented by two other important processes: the UN High-level Panel on the post-2015 development agenda, co-chaired by Indonesia, Liberia and the UK; and the inter-governmental Open Working Group on sustainable development goals, which is tied to the Rio + 20 process. These consultations bring the need for a new development agenda together with the call from the Rio + 20 world conference to establish a set of sustainable development goals.

Civil society groups have called for human rights and the principles of equality, non-discrimination and participation to be the basis of the post-2015 framework.

The recommendations published in May 2013 by the UN High-level Panel fell short in this regard; while some human rights are mentioned, such as non-discrimination against women, property rights, due-process rights and freedom of expression, there is no systematic integration of human rights in their proposal. The open working group on sustainable development goals will submit its proposal to the UN General Assembly in September 2013. Notably, the document that came out of the Rio + 20 conference makes firm commitments to human rights, including specifically the rights to health, to an adequate standard of living, to food and to non-discrimination.

One component of the UN global civil society consultation process focused on addressing inequalities, which offered minorities and indigenous peoples an important opportunity to participate in the creation of the post-2015 agenda. No equivalent opportunity was available when the MDGs were drafted.

The MDGs framework had many deficiencies for minorities and indigenous peoples. The reliance on aggregate results and the lack of disaggregated data collection meant that very few measurements were made on the progress of these groups towards the goals. Stretched resources and pressure to achieve the goals has prompted governments to focus on the populations that are easiest to reach and those whose levels of inequality were least costly to address. Linguistic barriers or differences in cultural or religious practices were often not taken into account when formulating national strategies on the MDGs. Thus, minorities and indigenous peoples now find themselves, in many cases, further from achieving the targets of the goals than other populations that have benefited from these interventions.

These trends are evident in some statistics regarding the health MDGs. In India, child malnutrition is about 14–20 per cent higher for Scheduled Castes and Scheduled Tribes and has been declining at a slower rate than for the rest of the population over the MDGs period.³ In Tanzania, the goal on reduction of HIV/AIDS was hampered for pastoralists in part because the national HIV/AIDS prevention campaigns were issued only in the dominant language of Swahili and antiretrovirals, although free, were not easily accessible in several districts where pastoralists predominantly live.⁴ In Pakistan, UNICEF reports that the maternal mortality ratio for Baluchistan – largely inhabited by the Baluchi minority – stands at 758 per 100,000 live births, nearly three times the national average of 276 per 100,000, and a long way off the MDG target of 140 per 100,000. The prevalence of malaria is very low in large parts of Bangladesh but is especially high in the Chittagong Hill Tracts, where the indigenous Jumma peoples reside, and largely attributable to less investment in adequate living standards and health services in this high-risk area. Chronic malnutrition among indigenous children in Guatemala is nearly twice the rate of non-indigenous children.

While governments may cite resource limitations or remote locations to explain these inequalities, they cannot be justified from the perspective of human rights.

The right to health: some key international standards and principles

Minorities, indigenous peoples and civil society organizations have all called for a human rights foundation to the post-2015 agenda. It is therefore important to discuss the scope of the human right to the highest attainable standard of physical and mental health (International Covenant on Economic, Social and Cultural Rights [ICESCR], Article 12). According to the General Comment No. 14 of the UN Committee on Economic, Social and Cultural Rights, which oversees the core treaty that recognizes the right to health, this right:

'is the right to the enjoyment of a variety of facilities, goods, services and conditions necessary for the realization of the highest attainable standard of health.... [The right includes both] timely and appropriate health care ... [and] the underlying determinants of health, including access to safe and potable water, and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, and access to health-related education and information, including on sexual and reproductive health.'

Thus, although the state cannot protect people against ill health, the state can provide services and an environment that enable people to achieve the highest possible standards of health.

Regarding underlying determinants of health, the ICESCR also recognizes rights to an adequate standard of living (Article 11), adequate housing (Article 11), food (Article 11), education (Article 13), and just and favourable conditions of work (Article 7). The treaty also requires states to take steps for 'the improvement of all aspects of environmental and industrial hygiene' (Article 12.2 (b)); 'the prevention, treatment and control of epidemic, endemic, occupational and other diseases' (Article 12.2 (c)); and the 'creation of conditions which would assure to all medical service and medical attention in the event of sickness' (Article 12.2 (d)).

Reproductive health rights for women are also firmly recognized: ICESCR holds that states should make 'provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child'

(Article 12.2 (a)), through measures such as access to reproductive and sexual health services, emergency obstetrics, information and resources to access these services. The Convention on the Elimination of all forms of Discrimination Against Women (CEDAW) has further provisions: states 'shall ensure to women appropriate services in connection with pregnancy, confinement and the postnatal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation' (Article 12.2).

Specific rights to health for children are detailed in Article 24 of the Convention on the Rights of the Child. These include the obligation of states 'to ensure that no child is deprived of his or her right of access to ... health care services' (Article 24.1); to reduce infant and child mortality (Article 24.2 (a)), to provide adequate nutrition and access to water and a clean environment (Article 24.2 (c)), and to 'develop preventive health care' (Article 24.2 (f)). Health rights and special measures are also noted for children with disabilities (Article 23).

The right to health for minorities and indigenous peoples

Against the backdrop of these general human rights provisions on the right to health we can sketch a framework that focuses on rights of particular concern to minorities and indigenous peoples: the right to non-discrimination; the right to participation and the right to protection of identity.

The right to non-discrimination

Everyone has the right to access health facilities, goods and services without discrimination (ICESCR and International Convention on the Elimination of all forms of Racial Discrimination [ICERD], Article 5.e.iv). This means non-discrimination both in access to health care and in enjoyment of the underlying determinants of health. States have obligations to prevent discrimination both by state actors in the public sphere and by non-state actors in the private sphere, including by private corporations. Crucially, even where resources are scarce, states cannot discriminate in the allocation of access to adequate health in the progressive realization of

this right (ICESCR, Article 2).

Non-discrimination in access to the right to health encompasses both positive and negative obligations of state actors. This requires more than the mere refraining from discrimination in providing access to and within health facilities, goods and services, but also taking positive measures, including through allocation of resources, legislative change or policy reform to ensure the fulfilment of this right.

Discrimination can be both direct and indirect. Direct discrimination results when a person is treated less favourably than another person in a similar situation based on prohibited grounds of discrimination. Indirect discrimination refers to practices that may appear neutral but nevertheless have the effect of discriminating on prohibited grounds. States have obligations to prevent both kinds of discrimination in access to health.

The right to participate

Fulfilling the right to participate will be essential for the post-2015 framework. The Committee on Economic, Social and Cultural Rights holds ‘the participation of the population in all health-related decision-making at the community, national and international levels’ to be an important dimension of the right to health.

Minorities have the right ‘to participate effectively in decisions on the national and, where appropriate, regional level concerning the minority to which they belong or the regions in which they live’ (UN Declaration on the Rights of Persons Belonging to National or Ethnic, Religious and Linguistic Minorities [UNDM], Article 2.3). Moreover, ‘[n]ational policies and programmes shall be planned and implemented with due regard for the legitimate interests of persons belonging to minorities’ (UNDM, Article 5.1).

Similarly, indigenous peoples enjoy the right to self-determination, including ‘the 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’ (UN Declaration on the Rights of Indigenous Peoples [UNDRIP], Article 23). Furthermore, states should obtain from indigenous peoples their ‘free, prior and informed

consent before adopting and implementing legislative or administrative measures that may affect them’ (UNDRIP, Article 19).

The right to protection of identity

Identity factors, such as cultural or religious life, can impact on the right to health for minorities and indigenous peoples. Beliefs about health and well-being, both individual and community, can be deeply rooted in cultural practices or religious beliefs that shape communities’ response to mainstream and strictly biomedical approaches to health care and health.

Minorities have the right to practise and to enjoy their own culture, to practise their own religion, and to use their own language, in private and in public, freely and without interference or any form of discrimination (UNDM, Article 2.1; International Covenant on Civil and Political Rights [ICCPR], Article 27). Indigenous peoples have the right to exercise self-determination over their cultural development (UNDRIP, Articles 3 and 11), to practise their traditional religions (UNDRIP, Article 12), and not to be subjected to forced assimilation or destruction of their culture (UNDRIP, Article 8.1). Protection of indigenous land and resource rights is interdependent with these rights (UNDRIP, Article 26).

Regarding traditional forms of medicine, Article 24.1 of the UNDRIP states that ‘Indigenous peoples have the right to their traditional medicines and to maintain their health practices, including the conservation of their vital medicinal plants, animals and minerals.’

Cultural and religious practices can also be harmful to health and some provisions have been made to overcome such harms; in the CRC, for example, states are to take measures for ‘abolishing traditional practices prejudicial to the health of children’ (Article 24.3), which could include both community practice and entrenched and systemic forms of discrimination coming from outside. More generally, CEDAW Article 5(a) calls upon states to eliminate customary and other practices based on assumptions of female superiority or inferiority, some of which can impact on health.

It is essential, however, that potential impact on health from traditional harmful practices not be used as a justification to prohibit outright

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Box 1
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Delivering the right to health

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The UN Committee on Economic, Social and Cultural Rights has developed a framework to define many of the minimum standards for delivering on the right to health in *goods, facilities and services*, including the underlying determinants of health. This consists of: Availability, Accessibility, Acceptability and Quality.

Availability. Health services should be readily available to all without discrimination. This includes sufficient provision of hospitals, clinics, trained health professionals and essential medicines. Services relating to the underlying determinants of health, such as safe drinking water, sanitation facilities, adequate housing and public education on health, must also be provided to an adequate level for all.

Accessibility. Health services must be accessible to all without discrimination. Services must be made affordable to all and must be located within safe and reasonable reach of everyone. Accessibility also includes the right to seek, receive and impart information on health, with due respect for confidentiality.

Acceptability. Health services must be provided in a manner that is compatible with cultural and linguistic rights, for example, by providing services in local languages and sensitive to different cultural practices. Health service delivery must also be responsive to gender and age differences. Medical ethics must be adhered to in the delivery of health services.

Quality. Health services must be culturally acceptable, scientifically and medically appropriate and of good quality. The provision of skilled medical personnel, quality drugs, safe water and good sanitation are among the minimum expected standards of quality. ■

the cultural and religious beliefs of minorities and indigenous peoples. Often what is needed is informed dialogue on how to reform certain specific practices without restricting or denigrating a culture or religion as a whole.

Understanding inequalities and inequity in health

The poor MDGs results for minorities and indigenous peoples can be attributed to state failures to fulfil their obligations to these groups. More than mere inequality, minorities and indigenous peoples also face inequity – distinguishable by the unfair and avoidable nature of the inequality witnessed. Inequity is therefore a better term to describe the unjust situation of minorities and indigenous peoples and the unwillingness of states to remedy this situation.

Discrimination

Discrimination is one key cause of health inequity. Discrimination can manifest in the access to health facilities, in the delivery of health services and in exhibited inequalities in the underlying (social) determinants of health like access to safe water, sanitation, adequate housing and nutrition, having higher rates of illiteracy, or working in more hazardous types of employment.

Direct discrimination occurs, for example, when health practitioners give less quality care to those discriminated against, evidenced by longer waiting times, inadequate diagnosis, the provision of less quality medication, patient segregation, or neglect in patient hygiene or nutrition. Indirect discrimination can manifest, for example, when access to information on health services and preventive practice is typically provided only in dominant languages or in accordance with dominant cultural practices.

Minorities and indigenous peoples are often also poorer than other groups, making fee-based health services much harder for them to use. Both direct and indirect discrimination can be compounding factors: in India, for example, although only about 1 per cent of disabled persons receive help from the government for education the percentage of beneficiaries among Dalits and Scheduled Tribes is about half that of the dominant caste group. This is likely

attributable both to direct discrimination and 'untouchability' practices, but also to higher rates of poverty among these groups.⁵

Culture and identity

A second key factor is the different priorities and perceptions of health that minorities and indigenous peoples often hold. This can stem from traditional cultural or religious beliefs about health and well-being, different customary practices around health care, or living in distinct locations with unique health challenges. In order to achieve better equity in health outcomes, these different viewpoints must be taken into consideration in policy development and service delivery.

Women's reproductive rights

Reproductive health rights warrant special attention here. There is evidence from around the world to show that women from marginalized minorities and indigenous peoples have disproportionately high rates of maternal mortality and often have less access to reproductive health services. In some severe cases, minority women can be coerced or intimidated into making involuntary decisions regarding their sexual and reproductive health, such as sterilization or (for or against) abortion.⁶ Both culturally based preferences and discrimination play a role in these outcomes.

Poverty and social exclusion

The underlying determinants of health can also be experienced differently by minorities and indigenous peoples. Disproportionately high rates of poverty and low rates of employment (or underemployment) affect these groups. They are typically pushed into jobs with higher occupational health risks as a result. Poverty contributes also to inadequate housing and less food security. All of these factors also contribute to higher rates of many non-communicable and some communicable diseases for minorities and indigenous peoples. In Pakistan, UNICEF reports that rates of polio are highest among the minority Pashtun population, comprising 77 per cent of cases. In Alaska, the Non-Communicable Diseases Alliance reports that indigenous Alaskans have twice the mortality rate from

rheumatic heart disease than non-indigenous Alaskans.

Displacement and land rights

Displacement from land is a major underlying cause: groups can be displaced from their land (to urban areas or to less fertile land), reducing access to traditional food sources and production. Achievement of the MDGs has been used to justify such displacement, usually with net negative outcomes for communities. In Mexico, for example, an MDG 'Sustainable Rural City' in Chiapas displaced indigenous communities into prefab settlements with the aim of improving access to health and other services. However, in the new houses, they could no longer grow their own food for consumption and income, nor cook their food staple, maize, thus putting pressure on incomes and food security; and while they were closer to health services, residents reported that the quality of such services was poor.⁷ The polluting effects of many extractive industries encroaching on traditional lands have also severely harmed health outcomes for these groups. In the Ahwazi-Arab minority region of Khuzestan in Iran, from where 90 per cent of the country's oil revenues originate, minority communities suffer ill health from the industry pollution of the Karoon River on which they rely.

These and other factors need to be taken into consideration when shaping the post-2015 agenda if the aim of health equity is to be achieved.

Post-2015 reforms: 'Leave no one behind'

The High-level Panel's final report published in May sketches out a vision for post-2015 reforms. While this vision does not fulfil a human rights-based approach, there has been some important recognition of discrimination and exclusion as barriers to sustainable development. The panel calls first and foremost to 'leave no one behind' in the post-2015 framework:

*'We should ensure that no person – regardless of ethnicity, gender, geography, disability, race or other status – is denied universal human rights and basic economic opportunities. We should design goals that focus on reaching excluded groups.'*⁸



Left: Māori mother and child, New Zealand.
Jocelyn Carlin/Panos.

To achieve this, the panel recommends that states build ‘accountable public institutions’ and enable ‘inclusive growth’, and that indicators of new goals be disaggregated by variables such as gender and ethnicity. The panel acknowledges that the ‘cost of delivering services in remote areas may be only 15 to 20 per cent higher than average’, and judges this to be ‘reasonable and affordable’ and ‘the right thing to do’.

These suggestions can help to meet the rights of minorities and indigenous peoples. Furthermore, the Rio + 20 outcome document emphasizes that policies for sustainable development and poverty eradication should: ‘enhance the welfare of indigenous peoples and their communities, other local and traditional communities, and ethnic minorities, recognizing and supporting their identity, culture and interests and avoid endangering their cultural heritage, practices and traditional knowledge’.

In order to ‘leave no one behind’, states should adopt specific targets that will ensure minorities and indigenous peoples achieve the right to

health through the new global development framework. A key tool for this is a national action plan to eliminate health inequity, including for minorities and indigenous peoples. National action plans, including the process by which they are devised, are considered by the UN Committee on Economic, Social and Cultural Rights to be a core obligation of ICESCR. National action plans should be elaborated with the full and effective participation of minorities and indigenous peoples, in accordance with their rights as outlined above. They should include clear indicators and benchmarks and be regularly monitored. National action plans must take a comprehensive approach to health inequity, rather than relying on isolated projects that cannot tackle underlying determinants of health. The new guidance note of the UN Secretary-General on Racial Discrimination and Protection of Minorities (2013) also offers some useful baseline recommendations for UN country teams to support these efforts.

Several states have taken positive steps in this direction. In the **USA**, the Department of Health and Human Services has recently outlined its action plan to reduce racial and ethnic disparities. This plan is being implemented in collaboration with existing Offices for Minority Health, which have been established in all 50 states and work to educate, monitor disparities, create community partnerships and develop targeted policies and programmes on racial and ethnic health inequalities.

In **Ireland**, the Traveller Health Strategy has involved members of the Traveller communities in reviewing national and regional health strategies to ensure that their interests and needs are reflected. The government has also launched an All-Ireland Study of Travellers’ Health Status and Health Needs, an extensive census-style examination of all Travellers in Ireland and Northern Ireland.

In **New Zealand**, a Māori Health Strategy and action plan have been adopted. This is supported by the Māori Health Business Unit, which provides evidence-based research on health strategies and by Māori health providers who

give on-the-ground service delivery. This strategy includes also an innovation fund, which supports positive Māori approaches that improve Māori health outcomes. In all three examples, there is a strong emphasis on target groups taking the lead in delivering these national strategies.

An alternative approach is to mainstream attention to minorities and indigenous peoples into general action plans on specific health sectors. In **Brazil**, for example, the National Pact to Reduce Maternal Mortality included specific objectives for ‘the inclusion of gender, race and ethnicity considerations in all strategies and measures’, and ‘the consideration of social inequalities in decision-making processes’.

Health targets can also be featured in any national anti-racism action plans (mandated under the UN Durban Declaration and Programme of Action from the 2001 World Conference Against Racism). This was pursued in **Ecuador**, where both indigenous peoples and people of African descent were targeted for culturally sensitive inclusion in health programmes. This was achieved through capacity-building and infrastructure development to ensure that medical services were culturally appropriate to these communities. The programme was linked to MDGs targets and included a specific project on culturally relevant childbirth preferences.

There are several key areas these national action plans could address.

Non-discrimination in health access and service delivery

Many practitioners have called for universal health coverage in the post-2015 aims but this cannot be achieved without specific targets for minorities and indigenous peoples and positive measures to tackle discrimination.

Collecting evidence

Mapping access to health services by minorities and indigenous peoples is a useful baseline that can help to determine relevant national targets. This should include an assessment of resource allocation to services in regions where these groups mainly live. Key quantitative and disaggregated indicators could include:

- information on the facilities by location, such as the number and type of hospitals and clinics and their user rates, including disaggregated data on users;
- details on the health service workforce, including by location, and points such as patient–health worker ratios, and disaggregated data on staff recruitment and promotion levels;
- information on health levels of the population, including prevalence of diseases, mortality rates and access to reproductive health;
- inventories on the equipment, types of facilities and quality and affordability of drugs at health services by location; and
- data related to underlying determinants, such as access to clean water, sanitation, secure land rights and adequate housing.

Baseline mapping needs to be accompanied by regular monitoring. Global datasets, health status statistics and access to universal health coverage should integrate disaggregated data on variables such as ethnicity, religion, language use and region, and intersect with data on sex, sexual orientation, gender identity, disability, age and other information relevant to marginalized groups. The UN Commission on Information and Accountability for Women’s and Children’s Health is one initiative that has recognized the need for such data on a global scale. Monitoring should focus both on access to health services and inequalities in the underlying determinants of health.

Data collection should be supplemented by qualitative, participatory approaches. Service user groups can be established to gather information from minority and indigenous groups on their experience of using health services. This can help to pinpoint particular problem areas, whether it be direct or indirect discrimination, lack of cultural understanding or poor outreach to affected communities. In British Columbia, **Canada**, an Aboriginal Maternal Health Forum was convened to invite First Nations women, particularly those living in under-serviced rural areas, to provide inputs on their perinatal health support needs. As part of this initiative, 26 First Nations women from two rural communities were trained as *doulas* (midwives).

Improving data collection capacities needs to

be built into the post-2015 framework. In the **UK**, the London Health Observatory's Ethnic Health Intelligence Overview provides an ethnic health database and data collection guidelines for health institutions across the city and nationally. Among the resources they have developed is a toolkit to help the National Health Service analyse ethnic differences in health and health care.⁹ Listserves on specific topics in minority and ethnic health have also been established for practitioners to share data, research findings and good practices.

Targeted measures to tackle discrimination

Targeted measures for especially excluded groups can also help tackle discrimination. Such needs can be identified through mapping and developed in national action plans.

- In **Serbia**, the Women's Association in Kovil provides weekly workshops for young Roma women who are wary of mainstream health services, and provides them with access to a paediatrician, pregnancy counsellor and other health information.
- In the **UK**, the Black and Minority Ethnic Health Forum has devised a targeted maternity health programme. The programme works with community-based organizations to reach out to minority women and provide them with information on maternal health services and how to raise their concerns with service providers and other relevant institutions. The programme also supports network building among minority women, who tend to be under-represented in mainstream maternal health networks.
- In **Australia**, an Indigenous Youth Health Service has been established to target vulnerable Aboriginal and Torres Strait Islander youth who are experiencing or at risk of homelessness, substance abuse and unequal access to sexual and reproductive health care, providing both clinical and non-clinical services.

Access to justice

Tackling discrimination also requires access to justice and knowledge of rights. Health Ombudspersons and other complaints

mechanisms should be established and take a role in monitoring for non-discrimination in access to health services. Patients should be instructed on their rights in relation to health services and have support to access remedies in cases of violations of those rights. In **South Africa**, a patients' rights charter was developed to give expression to the constitutional right to health. The charter is implemented through a number of complementary complaints systems mandated by the 2003 South African National Health Act 61, with support from the South African Human Rights Commission.

Such targeted measures have been recommended by UN treaty bodies. In the case of *Alyne da Silva Pimentel v. Brazil* (Communication No. 17/2008), the CEDAW Committee found that Ms da Silva Pimental, an Afro-Brazilian, faced discrimination on the basis of her sex, her status as a woman of African descent and her socio-economic background in access to emergency obstetrics services, resulting in her death. Moreover, the committee found that her family faced undue delay in access to justice when seeking accountability for her death. The committee called upon Brazil to 'ensure access to effective remedies in cases where women's reproductive health rights have been violated and provide training for the judiciary and for law enforcement personnel'. The establishment of maternal mortality committees at the local level was also recommended to monitor and investigate such incidents. These committees can be charged with reviewing medical but also non-medical and system-related factors that may have impacted on mortality rates, including differences across ethnic or other identity groups.

Training health professionals

Training and recruitment strategies need to be reviewed to deliver on health equity post-2015. All staff responsible for delivering both public and private health services need to be trained on non-discrimination standards and expected practices.¹⁰ This includes understanding and reforming their own prejudices and discriminatory behaviours, as well as understanding wider societal inequalities and injustice along these lines, and their interaction



with health. Recruitment should aim for a proportionate level of staff from minority or indigenous communities, especially in regions where the population of these groups is high. Targeted training programmes or scholarships for health-related studies can be offered; **Hungary**, for example, has created pre-training programmes for Roma for health care careers. Given that language can be a significant barrier for members of minority and indigenous communities seeking medical assistance, staff should be recruited who speak relevant local languages, or should be trained to speak local languages.

Culturally adapted health services

Cultural and religious variables were ignored in the one-size-fits-all approach of MDGs but must figure in the post-2015 agenda for it to be effective. The health-related agenda needs to be adapted to the cultures, religious beliefs and lifestyles of minority and

indigenous communities. Specific targets for the establishment of inter-cultural health schemes can be adopted.

Health services designed to meet the post-2015 aims should include specific provisions for minorities and indigenous peoples. For example, this could mean making public health campaigns available in minority languages and media outlets. Those same campaigns could be adapted to reflect different cultural practices or religious beliefs related to health issues, to ensure that information is better understood and responded to. At another level, minorities and indigenous peoples may require distinct health policies that depart from the mainstream post-2015 framework. Such group-specific policies would respond to significant differences that groups can express in terms of their worldview on health and well-being.

In **Ethiopia**, for example, Health Poverty Action has been working with pastoralist

Left: A health mediator assists a Roma community in Bulgaria. *Tzvetina Borisova/SETimes.*

communities to create traditional birthing huts where pastoralist women can give birth safely and in accordance with customary beliefs but also be referred to equipped health facilities if complications arise.¹¹ In **Panama**, the government has created an ‘Office of Traditional Medicine’ under the Medical Bureau and a medical commission for the purpose of ‘harmonizing and fusing western with traditional medicine’.¹²

More research is needed into culturally specific practices and beliefs related to health. This should include analysis of both positive and negative impacts on health of such practices and beliefs. In the **UK**, numerous studies have been done to highlight inequalities by ethnicity in access to health services under the auspices of the Better Health initiative. Better Health has produced a briefing collection, providing studies to help practitioners understand how minorities have differing experiences of health care in areas like mental health, maternal health, certain diseases such as cancer or diabetes, or people with learning disabilities.

For many indigenous communities, access to traditional medicine can supplement services from mainstream health facilities. The Ba’Aka in Cameroon have poor access to health services but have used their traditional medicine skills to use forest resources to support their health; where they are displaced from access to such resources, health levels decline. Specific rituals and taboos associated with childbirth also greatly impact on uptake of mainstream services. For example, in Bolivia, a micronutrients programme is failing to reach many pregnant women because it does not take into account the traditional diet of indigenous groups, including taboos related to certain foods during pregnancy.¹³

Training for all health services staff is needed on cultural impacts on health and use of health services. Specialized staff with expertise in communities that experience discrimination can help to ensure better access to health services. This strategy has been adopted in **New Zealand** with the creation of Māori Health Providers.

In at least six countries in central and eastern

Europe (**Bulgaria, Romania, Slovakia, Serbia, Ukraine and Macedonia**), there has been a similar widespread programme of Roma Health Mediators. They provide various services, including referring clients to the appropriate health services, assisting in outreach with public health campaigns, and making legal referrals in cases of discrimination or abuse, as necessary. The mediators have had success in increasing vaccination rates among Roma, in enabling them to acquire necessary identification and insurance documents, and have educated communities on health and improved health care provider knowledge and attitudes about Roma.¹⁴ Notably, some of the weaknesses of the programmes have been insufficient resource allocation, poor institutional support for the mediators and continuing neglect of many underlying determinants of health for Roma by governments. The report recommends addressing these problems and also taking steps to ensure mediators are better integrated into the health system, are collecting more detailed data on outcomes of interventions, and that there are more opportunities for health and social policy officials to learn from mediator experiences.¹⁵

Addressing underlying determinants of health

Many agree that the World Health Organization’s major review of social determinants of health concluded in 2008 needs to figure centrally in the post-2015 agenda. This is crucial for addressing health inequities of minorities and indigenous peoples, which often stem from differences in social determinants. The drive towards a ‘Health in All’ approach to mainstreaming health considerations across multi-sectoral public policies similarly can help to create a more comprehensive approach to improving health in the post-2015 development sectors.

Poverty

Poverty reduction strategies targeted at minorities and indigenous peoples would tackle a key underlying determinant of their health. Specific targets on poverty reduction for minorities and indigenous peoples need to be adopted. As noted above, disproportionately high levels of poverty

for these groups are in evidence across the globe, suggesting that poverty reduction efforts are not benefiting them equally. For example, cash transfer schemes have been shown to be effective for many poor people but may be less effective for minorities who can face discrimination in access to services, including in health. Poverty may also increase other social problems in communities, such as abuse of alcohol or drugs, that impact greatly on health. Poverty also pushes groups into more hazardous forms of employment, which can be better regulated through safety measures and other monitoring and legal protections. The post-2015 health agenda needs to take account of these distinct forms and effects of exclusion.

Land and natural resources

Land is a critical determinant of health, and minorities and indigenous peoples typically have less legal protection for their land rights and less access to quality land. They may also be more vulnerable to 'land-grabbing' or involuntary displacement from their land. The net effect is that minorities and indigenous peoples often lose livelihoods, food security, traditional forms of housing and access to spiritual practices, increasing poverty and lowering physical and mental health outcomes.

The post-2015 framework needs to approach land rights and displacement differently, including by developing targets on access to land. Repeated cases show that forcibly displacing people to increase access to health services has actually had negative impacts on health for the reasons outlined. Investment in local health services for communities living more remotely is a more sustainable and cost-effective approach.

Making land security a top priority post-2015 will have a strong multiplier effect on health outcomes, underpinning key issues like poverty reduction, employment and food security. Any targets on nutrition will have to consider the link to land displacement. Where large-scale development of land is pursued, communities should give their consent to such processes and legally enforced benefit-sharing agreements, and/or just and equitable compensation for land and resources, should be secured. In **Cambodia**, some indigenous communities are receiving

UN funding to map their ancestral lands in an effort to secure communal land tenure; this will hopefully help safeguard traditional ownership of land from encroachment by companies entering indigenous territories.

Protection of the environment will figure prominently in the post-2015 framework. Rio+20 recognized that the right to health is an essential component of sustainable development. Many minorities and indigenous groups use natural resources sustainably and responsibly but they also face the polluting effects of industry on their land and the harsh impact of climate change on their local environment.

Access to justice and legal aid for marginalized groups to hold actors to account for environmental harms should be one dimension of post-2015 environmental reforms. Cooperation with minorities and indigenous peoples in developing locally owned natural resources management schemes can also help deliver the Rio aims in a way that does not force people off land, away from their resources and further into poverty.

Participation

Lack of political participation is another determinant of health. The inability of minorities and indigenous peoples to secure fair allocation of resources in national budgets is but one dimension. Targets for minorities and indigenous peoples on greater representation in political institutions at different levels can be developed. Health Poverty Action has been working with indigenous women in Peru to build their advocacy capacities to engage local and regional government in dialogue on their failure to deliver adequate nutrition programmes. The programme has also included institutional capacity building for women's organizations, for example on budgeting, as well as integrating men into discussions on traditionally gender-based domains of work, thus helping to tackle gender inequality.

Conclusion

The bold experiment of the MDGs has yielded mixed results but it has taken the world closer to the realization of human rights for all. For the post-2015 framework, we need to be bolder

and also smarter in how we tackle inequality. Adopting specific and concrete targets and building capacities to include minorities and indigenous peoples in the new global agenda is a key piece of the puzzle for achieving sustainable development for the 21st century in both the global North and South.

'Health in All' policy approaches are needed for a new cross-cutting strategy post-2015. The case of minorities and indigenous peoples illustrates well how underlying determinants of health across many sectors, from land development to education and employment and environmental protection, impact on access to adequate health. The more holistic cultural and religious view of health and well-being held by many minority and indigenous communities can also inform the mainstream approach to health care, moving us all beyond narrow biomedical prescriptions.

Strategies for building the capacity of minorities and indigenous peoples to claim their right to health, and for governments to respect, protect and fulfil this right, should be included in post-2015 plans. Human rights-based approaches to health rooted in non-discrimination, participation and accountability are needed. A key component of this is putting in place adequate monitoring and accessible accountability mechanisms to counter discrimination. Such mechanisms should be sensitive to and respectful of the differing cultural and religious views of groups that influence their priorities and activities in development. Ensuring the participation and leadership of minority and indigenous groups in the elaboration of policy and programme responses is also essential for creating interventions that will work better in reaching our common goals for sustainable development. ■

Endnotes

1. Parts of this chapter have been reproduced with permission of the Indian Institute of Dalit Studies from a working paper prepared by the author on *Good Practice in Combating Discrimination in Access to Education and Health: International Norms and Local Strategies* (July 2012).

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Improving indigenous maternal and child health

Viviana Crivelli, Juan Hautecoeur, Coll
Hutchison, Ana Llamas, Carolyn Stephens

In the public hospital in Otavalo in Ecuador, indigenous women have seen a major change in their maternal and child health services and this has increased their trust in the system. In the past, discrimination was a major problem, and women were not allowed to use their traditional birth practices or bring their traditional birth attendants (TBAs) with them. They were not able to explain all the factors that they felt important for their children's health. Now since the introduction of a national Vertical Birth Policy – many indigenous women traditionally give birth standing up – a Universal Health Care Policy, and the introduction of TBAs into the hospital system, indigenous women feel less discriminated against (see Box 1).

Discrimination towards indigenous peoples and minorities is a global problem, and indigenous populations internationally experience extreme marginalization and poor health. Indigenous women are particularly disadvantaged during pregnancy and children during infancy. But before we look in detail at health in indigenous women and children it is important to describe briefly the historical and cultural context of indigenous health worldwide.

The context for indigenous maternal and child health

The current marginalization of indigenous peoples has a long history. Five hundred years ago in Latin America, millions of people were displaced, killed or lost their lives to introduced diseases in the course of the Spanish and Portuguese invasions. In Asia, Africa and the Middle East the situation of minorities and indigenous peoples is linked to their historical relationship with majority ethnic or religious groups. For example, in India indigenous groups, known as tribal peoples, are often seen by scientists and policy-makers from the majority culture as backward and their health problems are blamed on their culture and bad habits.

To an extent, the policy support and attention indigenous peoples receive in their countries relates to the size of their populations. In some countries, for example Bolivia, indigenous peoples are the majority population, and there is an indigenous president. However, in most countries indigenous peoples are a minority of

the population, and often culturally diverse in terms of both the majority population and other minorities, with very different ways of looking at health and their own health systems. For example, according to the 2000 Census, China has 55 different indigenous populations, totalling 104.49 million people, but comprising only 8.1 per cent of the country's total population. Each of these groups has their own language and culture, highly different from each other and from the majority culture.

Box 1

One indigenous woman's perspective on discrimination in the health system

When I started to work in this organization we used to attend talks about our rights, about pregnant women's rights, about the rights that the state guarantees and the right to health, that nobody can tell us off or discriminate against us ... Before, I didn't know we had rights, you even felt bad for being indigenous because there was discrimination everywhere, in education, in health ... in the street they used to call us 'indians, longas' [pejorative terms used to insult indigenous people]. We used to say nothing but after those talks [in the organization] and the self-identification as indigenous you start seeing things more clearly and you can defend yourself. If anyone tells me off without justification I can answer back. So I wanted to deliver in hospital because we needed it for my husband's [paternity leave] and because I wanted to help others, because there is so much injustice.

Indigenous woman, aged 30, Otavalo Public Hospital, Ecuador, 2012¹ ■

It is important to realize that for many indigenous communities 'health' is a concept linked to the community, not the individual; it has an important spiritual element and relates strongly to the well-being of the ecosystem and planet. This has important implications for how we measure and treat health in indigenous peoples. Allopathic medical models, often termed 'western' medicine, tend to treat symptoms of individuals, and measure 'health' with statistics regarding individual illness and mortality. This chapter uses some of these statistics but also reports from indigenous community members about their own perspectives on health.

If we look at what we know globally from scientific studies and government reports, indigenous health data is better documented in Australia, North America and New Zealand, where approximately 1.1 per cent of the world's indigenous populations live. The health of indigenous peoples in lower-income regions – including Latin America, South Asia and Africa – has received significantly less scientific and policy attention. A *Lancet* series² on global indigenous health identified several key themes:

- Lack of data: indigenous identity is not recognized by some national governments, and where indigenous peoples are recognized, data are rarely routinely collected or disaggregated.
- Where data exist, evidence suggests that, in all settings, indigenous peoples suffer extreme ill-health and many population groups are at risk of demographic extinction.
- Indigenous peoples' concepts of health differ from western biomedical models. Rarely focusing on individual well-being, indigenous people see their personal health as intimately linked to that of the wider community and ecosystem in which they live.
- Socio-political factors linked to marginalization and colonialism, and relationships with the land and environment, are seen as fundamental determinants of indigenous health.

Concluding the series, *The Lancet* editor Richard Horton commented: 'perhaps the most urgent call of all is to remove the cloak of invisibility from the shoulders of indigenous peoples'.³ The problem is that in many countries, indigenous peoples are not *visible* within census or routine

statistics. This is important for understanding indigenous health problems. There is no universally accepted definition of 'indigenous' and countries may use very different ways of identifying the indigenous population and of registering this status in health data. For example, census and population surveys often base their statistics on indigenous populations on surveys that use a measure of self-identification as indigenous by respondents. Problems emerge where indigenous peoples experience discrimination, and they often do not want to self-identify as indigenous as it is stigmatizing. As policies change and discrimination decreases, the indigenous population may seem to increase, but this is simply because more indigenous people are willing to self-identify as indigenous.

In some regions, it is the government that does not wish to recognize the concept of 'indigenous'. This is most pronounced in Africa, where there are an estimated 14.2 million self-identifying indigenous people, including hunter-gatherers, such as Batwa in central Africa and San in Botswana; and pastoralists such as Maasai in Kenya and Tanzania, and Tuaregs in west and northern Africa. Almost all these communities face discrimination, displacement and conflict with national governments and majority populations.

Health data may be even more problematic than population data – people's ethnic status is rarely measured in health statistics and data are rarely disaggregated. If you add these statistical problems together with the demographic reality that indigenous peoples may be a small proportion of national population in most countries, indigenous peoples can be rendered invisible. Women and children can be particularly voiceless, and their needs overlooked.

Keeping this background context in mind, we can start to look at the evidence of the health situation faced by indigenous women and children. Gender inequities exist in almost all settings – girl children are disadvantaged in infancy, women are disadvantaged in health terms, access to education, employment and social services. In almost every country, indigenous and minority women and children have worse health indicators than non-indigenous and non-minority women and children.⁴

The context of indigenous poverty and

inequity underlies the health profile of indigenous women and children. But this is not the only problem: indigenous peoples often live in remote inaccessible areas, which are often home to natural resources that are important to majority populations in their countries.

Many communities may not have access to basic services such as clean water, sanitation, education and health, but as importantly, they are often displaced from their homes through deforestation, resource extraction and conflict. In urban areas, indigenous peoples often end up in low-income settlements in the worst environmental and social conditions. And even when services are available to indigenous communities they are often not adapted to the needs of culturally distinct indigenous peoples.

Indigenous child health

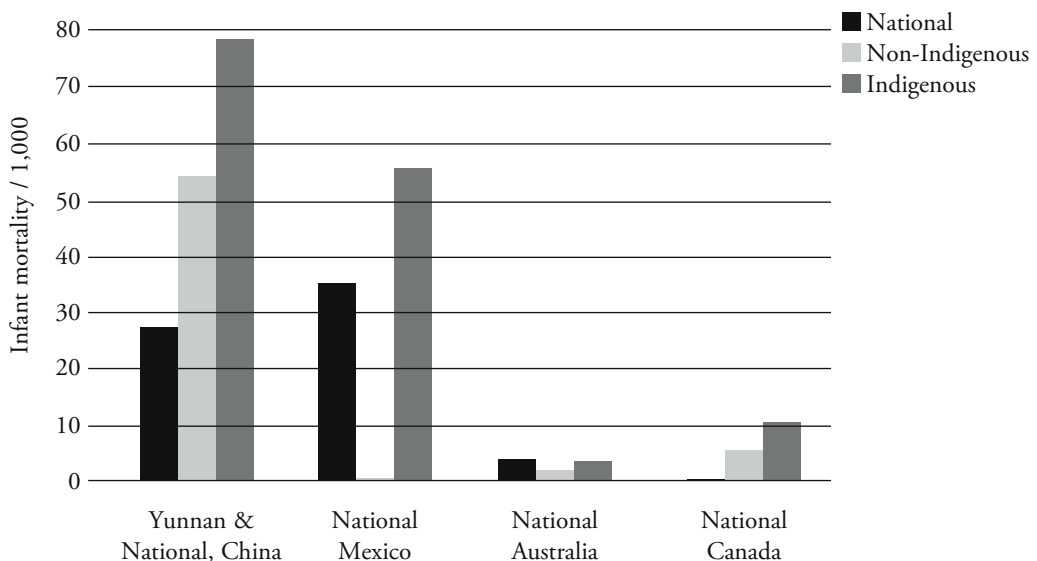
International studies show that indigenous children have worse health indicators than non-indigenous children in almost every context.⁵ They have higher rates of infant mortality, and higher rates of illness, including respiratory and diarrhoeal disease. In the Republic of Congo, mortality from measles has been estimated to be five times higher in Ba'Aka children than neighbouring Bantu communities.⁶

While health problems are common across the world, the scale of the health problems, and of inequities between indigenous and non-indigenous groups, varies widely between countries. For example a study in China found that infant mortality rates (IMR) for indigenous groups in Yunnan Province were 77.75 per 1,000, compared to a national IMR of 26.9 per 1,000, and an IMR of 53.64 per 1,000 for non-indigenous populations of Yunnan.⁷ In Mexico, municipalities with a high proportion of indigenous peoples in their population had an IMR of 55.1 compared to a national IMR of 34.8 per 1,000. This study also showed that there are important inequalities between indigenous groups – the highest IMRs were in the indigenous regions with the worst socio-economic conditions.⁸

Figure 1 shows the IMRs in Yunnan compared with the national data in China, as well as in three other countries.⁹ It is based on different studies from different periods but it does allow us to see the striking differentials in between indigenous and non-indigenous populations and countries with different regions and socio-economic conditions. It also highlights the differences between countries.

Indigenous child health indicators can be equally poor. Indigenous children often suffer

Figure 1 Infant mortality for indigenous and non-indigenous children in four countries



malnutrition and childhood diseases at rates higher than non-indigenous children. Indigenous children also often have poorer nutrition indicators, with both under-nutrition and malnutrition, and have higher intestinal parasite loads, than non-indigenous children in their settings. In Misiones in Argentina, there are a remaining 78 Mbyá Guaraní communities with 4,083 members. Studies indicate that 57 per cent of Guaraní children under five years were undernourished and 43 per cent suffered chronic under-nutrition.¹⁰

As they grow into adolescence, particularly if they are exposed to so-called western lifestyles, they are vulnerable to drug and alcohol addictions, with young girls also vulnerable to sexual abuse and prostitution. Young girls are particularly vulnerable when major infrastructure projects move into their remote regions, bringing outside workers who look to the young girls for sex work.¹¹

Mental health problems and suicide rates among indigenous young people can also be higher than those in the non-indigenous population. This is often linked to ‘acculturation’, particularly if the indigenous community has been forced into urban settings, where urban indigenous children and their families often experience the worst situations of urban marginalization, discrimination and poverty.

Some evidence suggests that maternal health plays an important role in protecting young indigenous people from mental health problems, even in extreme circumstances of displacement.¹²

Indigenous maternal health

Indigenous women are most often the key carers of children in their communities. TBAs are a very important health resource in the community, and many traditional healers are women. In many indigenous cultures in Latin America, an elderly indigenous woman in the community is chosen each year to become the Pachamama (or Earth Mother), advising the whole community and guiding them towards a caring relationship with the environment.

In interviews with Doña Celia Andrade, Pachamama of the Calchaqui Valleys of Tucumán in northern Argentina, she told us:

Box 2

Indigenous maternal health – a perspective from Ecuador

‘With my first child, the doctors told me that I would deliver around 3 p.m. and that if I needed anything before that I should ring the bell. I was left alone [in the labour ward]; I rang the bell many times because I needed to go to the toilet. I rang the bell for half an hour and nobody came. Then, a doctor in a suit who was not on duty turned up by chance. I told him I wanted to go the toilet, I had been calling for help and nobody was coming. ‘Are you in labour?’ the doctor asked. ‘Yes, and I can’t cope any more!’ I said. He checked me with one of those machines you put in the tummy and he said ‘This baby is about to die!’ And the doctor gave a cut to deliver. It turns out that the doctor who was on duty had gone to the park with a friend and didn’t come back on time; so the doctor in the suit delivered me. My daughter was born very, very blue and with a very big head. That’s why I didn’t want to go back to hospital because [health care workers] say it’s not time [for delivery] yet and they leave.’
‘Graci’ – a pseudonym

After this first experience Graci wanted a homebirth for her second child. However, she delivered her second child in hospital too because, as she explained, her feet swelled up and she felt a strong burning sensation all over her body. Her husband and her sister said this was not normal and, although she did not want to go to the hospital, eventually her husband and sister persuaded her. According to Graci, her second experience was very different. Research data showed that at that time, the hospital had implemented the

Vertical Birth and the Universal Health Care Policy.

'I think the second time care was good because the doctor and the indigenous TBA were [on the labour ward]. The TBA is employed there and they are with the patient. The same for doctors and nurses, they are there with the patient; now they don't leave you alone ... What is also very good is that now a relative can stay with the patient ... My sister was with me [during labour] and she told me I could [deliver], because I thought I couldn't cope. When I was about to deliver my sister told me I had to push and that I could do it and then the baby came out. My sister told me "It's a boy!" and the doctors also

said "It's a boy!"' Graci'

Graci's sister, Marta, who also happened to be pregnant, was due to deliver a few months after Graci. As Marta stated, initially she wanted a homebirth but she delivered in hospital because she felt strong cramps during labour and felt she would not be able to deliver at home. She was encouraged by her sister Graci to go to the hospital because 'care in the hospital is good now'.¹³ ■

Below: An indigenous woman feeds one of her children in a river, Ecuador. James Morgan/Panos.



'When I was young and a mother, I cured my children with our medicines, with herbs, with good food. Now that I am Pachamama I see young mothers who do not have such good food for their children, who do not have time to cook for their children. These children are our future and we have to care for them with good food and health, and with our knowledge of our medicines and our love for our planet.'

Despite their cultural importance and knowledge, indigenous women are often highly marginalized in their national and local contexts. They are generally the key holders of traditional food and medical practice, but may speak only their native languages, and are often unused to communicating with people outside of their community. As a result indigenous women often experience extreme prejudice in their contact with the outside world, particularly in health and social services.

Pregnancy can be a particularly difficult time: the official health system of most countries is not based on cultural sensitivity towards indigenous women, and they are often treated with disrespect and prohibited from following their traditional birth practices. As a consequence, indigenous women in many settings do not access the formal health system, or access it only in emergencies, often too late.

Box 2 (on p. 28) shows the experience of one indigenous woman and her sister during two pregnancies in Otavalo Hospital in Ecuador talking about their feelings about care during pregnancy and delivery.

The experience of indigenous women in Ecuador is very similar to that of indigenous women across the world. Indigenous women rarely receive culturally appropriate care within a western health care system and this is particularly problematic during pregnancy. Risks to maternal health are often the same as for any pregnant woman, and include complications during pregnancy and in delivery. Data can be incomplete as indigenous women often distrust the health systems and do not access services, but studies show that indigenous women have higher rates of maternal mortality than non-indigenous women.¹⁴

From a health service perspective, indigenous

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Box 3
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The MDGs

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- Goal 1 Eradicate extreme poverty and hunger
- Goal 2 Achieve universal primary education
- Goal 3 Promote gender equality and empower women
- Goal 4 Reduce child mortality
- Goal 5 Improve maternal health
- Goal 6 Combat HIV/AIDS, malaria and other diseases
- Goal 7 Ensure environmental sustainability
- Goal 8 Develop a global partnership for development

women may also have health behaviours that put them at risk, such as smoking during pregnancy, and they may delay attending health services until the last stages of an emergency, giving health staff very little time to help them.

Gender inequities within the household also play a significant role in indigenous maternal health: one study in Mexico among indigenous women in Chiapas found that decision-making was dominated by husbands and their families, and that 98 per cent of indigenous women only spoke their own indigenous language and did not access outside services. Western maternal health services were not used at all: 49 per cent of all obstetric cases were assisted by TBAs, 45 per cent by relatives and 6 per cent by their partner.¹⁵

The Millennium Development Goals and indigenous maternal and child health

Box 3 shows the Millennium Development Goals (MDGs), adopted initially in 2001. Since their introduction, indigenous peoples' organizations, international non-governmental organizations (NGOs) and UN bodies have expressed concerns about the MDGs process, particularly in relation to measurements of indigenous well-being.



Above: Aboriginal children at a health clinic in Ramangining, Australia. Penny Tweedie/Panos.

Concerns relate principally to the issues of measurement of indigenous population, along with economic, social and health statistics mentioned earlier in this chapter. For example, Jane Freemantle, writing for the *UN Chronicle*, reports that, even in Australia, it is estimated that only 59 per cent of Aboriginal and Torres Strait Islander children (under 15 years) are included in national infant and childhood mortality statistics due to incomplete and inaccurate identification in some states and territories. Freemantle comments:

'Without accurate identification of indigenous persons in health datasets, we cannot accurately describe and monitor indigenous births, deaths,

*and child health outcomes. We cannot answer the questions: Who are our indigenous peoples? What is their current standard of health and how does it compare to other members of the population? Why is their health so poor and how can opportunities for better health care and health outcomes be supported and increased?'*³⁶

The key solution to the problems of the MDGs and indigenous well-being is in the development of *disaggregated* MDG indicators for indigenous peoples within countries. For example, Goal 4 is to reduce child mortality. The specific target of MDG 4 is to reduce the under-five mortality rate by two-thirds, between 1990 and 2015. The indicators for MDG 4 are under-five and IMRs, and the proportion of one-year-old children immunized against measles. These indicators could be disaggregated in order to measure rates

within indigenous populations – this would allow us to know if indigenous peoples were being left behind in the overall MDG race. This is a key civil society policy recommendation for any post-MDG framework.

Policy responses

Despite the continued problems of indigenous maternal and child health, significant progress has been made at both the international level and within countries. In terms of data collection and documentation of indigenous health issues, UN agencies, NGOs and indigenous organizations have been pushing for disaggregated data for indigenous peoples for some years.

Some countries, such as Argentina, Bolivia, Brazil and Ecuador, now include census questions that allow the population to self-identify as indigenous if they wish. This helps to identify the size of the indigenous population but needs to be combined with indicators of indigeneity within data collected by health, education and other government agencies.

In 2007 the UN Declaration on Rights of Indigenous Peoples was ratified. It emphasizes indigenous peoples' rights to health and to their own definitions of health and well-being. The declaration also emphasizes indigenous rights to the conservation of medicinal plants, animals and minerals – an important element linked to the natural resources that indigenous peoples rely on.

At national level, indigenous peoples have been supported by a number of governments. Health services have been adapted and training of medical professionals has been made more culturally sensitive. In several states, governments have trained indigenous peoples to become health workers and developed inter-cultural health services.

Some of the most interesting examples of initiatives are found at the local level. For example, the implementation of the Vertical Birth Policy in Ecuador was principally driven by indigenous groups both within and outside the Ecuadorian government. This has not been easy but has gradually changed the face of the health system for indigenous women and their families.

In other contexts, indigenous women have been involved in the development of research into maternal mortality and maternal health

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Box 4
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Health-related Articles of the UN Declaration on Rights of Indigenous Peoples, 2007

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Article 24

1. Indigenous peoples have the right to their traditional medicines and to maintain their health practices, including the conservation of their vital medicinal plants, animals and minerals. Indigenous individuals also have the right to access, without any discrimination, to all social and health services.
2. Indigenous individuals have an equal right to the enjoyment of the highest attainable standard of physical and mental health. States shall take the necessary steps with a view to achieving progressively the full realization of this right.

Article 31

1. Indigenous peoples have the right to maintain, control, protect and develop their cultural heritage, traditional knowledge and traditional cultural expressions, as well as the manifestations of their sciences, technologies and cultures, including human and genetic resources, seeds, medicines, knowledge of the properties of fauna and flora, oral traditions, literatures, designs, sports and traditional games and visual and performing arts. They also have the right to maintain, control, protect and develop their intellectual property over such cultural heritage, traditional knowledge and traditional cultural expressions.
2. In conjunction with indigenous peoples, States shall take effective measures to recognize and protect the exercise of these rights.



policies. For example, indigenous women in Australia were involved in the development of vaccine policy and antenatal care.¹⁷ As a result, previously autonomous indigenous health providers were incorporated into a community-based, collaborative Mums and Babies programme for indigenous women in Townsville. A subsequent study found that the number of indigenous women who entered the programme and gave birth at Townsville Hospital trebled in three years to 61 per cent.

A major step forward for indigenous health generally has been the development of education programmes to incorporate indigenous young people into medical and nursing training, often with concurrent development of inter-cultural health education in medical schools. One particularly successful programme in Australia explored what indigenous communities in northern Queensland want from their medical doctors. This included culturally appropriate knowledge and communication. The programme

Above: Medical students from the high Andean valleys of Salta, Tucumán and Catamarca, Argentina. *Carolyn Stephens.*

also incorporated indigenous perspectives and indigenous practitioners into medical schools.

The photo above shows young medical students from the high Andean valleys of Salta, Tucumán and Catamarca celebrating the first programme of social inclusion in medical education initiated by the National University of Tucumán in Argentina. These students are the first group from their communities to be trained as doctors, with a concurrent programme of indigenous health training introduced into the medical faculty in 2013.

Conclusion

There is a long way still to go to bring indigenous maternal and child health up to the standards of their right to 'the highest attainable standard of physical and mental health'. Making

visible the current situation is one important step forward. If governments internationally make a commitment to routinely disaggregate data on indigenous populations, their health and their social and economic situation, this would be another important step forward. The MDGs are an important initiative that governments internationally have signed up to, but they have not yet acknowledged formally the need to have indicators disaggregated for indigenous health.

Finally, we need to recognize that indigenous peoples are an important representation of human cultural and linguistic diversity. They are often the guardians of the most critical natural resources of the planet and have a unique understanding of these environments. They have a key contribution to make to medicine internationally and to the health of all peoples. The health of indigenous mothers and children is vital for the survival of indigenous populations internationally. And the survival of indigenous peoples is linked intimately to the survival of the planet and all of us. ■

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Minority women's
vulnerability to
HIV/AIDS in
South East Asia

Nicole Girard

Mar Yee first learned she had been infected with HIV in 2005. Pregnant and away from her home in Karen State, Burma, Mar Yee had few health care options. In Burma, health care infrastructure is extremely poor, lacking even basic facilities and equipment, strained after years of civil war in many areas of the country that are home to ethnic minority populations. Mar Yee, like many others from her Karen ethnic group, fled to Thailand in search of the opportunities and stability that she simply couldn't find at home. By her early 20s, she was living with a man who gave her enough money to support herself in return for sexual favours. It was this man, she suspects, who gave her HIV. After she grew tired of the lack of any emotional bond, she dated another man, with whom she eventually got pregnant. As an undocumented migrant in Thailand, there were no public health options available to Mar Yee. She, like thousands of other women who find themselves in the margins between Thailand and Burma, had to depend on an NGO clinic for antenatal care, where HIV testing is part of their services.

In South East Asia, many women from minority and indigenous communities have similar stories to tell. But that does not mean their stories have been included in the official accounts of women living with HIV in South East Asia. In fact, in a region that has the second highest HIV rate after Africa, as well as the highest numbers of indigenous peoples (an estimated two-thirds of the world's indigenous population lives in Asia), the struggle of indigenous and minority women and their right to health remains largely invisible.

UNAIDS estimates that there are about 1.2 million people living with HIV/AIDS in South East Asia, 37 per cent of whom are women. The countries with the highest number of people living with HIV/AIDS are Burma and Cambodia, Indonesia and Thailand. Unfortunately, the experiences and vulnerabilities of women belonging to minority and indigenous groups are lost in these numbers; there are no official figures for HIV rates for minority and indigenous women or men.

HIV interventions in South East Asia have largely focused on groups considered high-risk, including sex workers, men who have sex with men, and people who inject drugs, whose rates

have been increasing, as opposed to the general population. Female partners of men who use sex workers or intravenous drugs are also an increasingly acknowledged at-risk group. But the focus on these specific at-risk groups can ignore those who are vulnerable to contracting HIV or are denied access to services because of systemic discrimination along ethnic, religious and linguistic lines.

And there is reason to be concerned. Although UNAIDS states that 'no country in the region has a generalized epidemic' (when HIV prevalence is 1 per cent or more in the general population), in some areas where minority and indigenous populations reside, HIV prevalence has reached a generalized epidemic. For example, in the highland provinces of Papua, Indonesia,¹ HIV is spread mainly through heterosexual transmission. Gender-based disparities mean that married women often have little say with regard to condom use; the epidemic therefore threatens to disproportionately affect indigenous women living in those areas.

The cases from Thailand and Burma, Vietnam and Papua described below show that some minority and indigenous women in South East Asia have a higher risk of contracting HIV/AIDS and are not receiving the treatment they need. These women are particularly vulnerable for a range of factors: gender inequality, ethnic discrimination, unequal access to health care and education, conflict and associated human rights abuses in the areas they live, and poverty and lack of opportunities. Although there is little data on HIV prevalence rates among minorities and indigenous peoples generally, and minority and indigenous women in particular, international organizations, government and health care professionals must be more aware of the issues affecting women from minority and indigenous communities, and how to address their particular needs.

Papua, Indonesia

*'A lot happens in society, where women who don't know anything in the end contract HIV/AIDS because of their husbands' "snacks" outside [the home]. They get cash from Special Autonomy funds, then in a matter of days use it up paying prostitutes and buying liquor.'*²



Papua was forcibly incorporated into the Indonesian state in 1969 and since then its people have struggled to realize their rights in the face of militarization and conflict, mass in-migration of Indonesians from other areas of the country, and development projects that leave little money in the hands of Papua's indigenous people. The 2001 Special Autonomy law was intended to give the province more fiscal and administrative autonomy, but many of its provisions remain unimplemented.

HIV infection rates in Papua are 15 times the national average, but since the government does not collect data disaggregated by ethnicity, this figure obscures how hard indigenous Papuans are hit. In 2008, UNAIDS estimated that the HIV prevalence rate was 2.4 per cent among the general population, but reached 3.4 per cent in the indigenous Papuan populated highlands.³ Some experts estimate that prevalence rates are as high as 7 per cent to 10 per cent in the highlands.⁴ The epidemic is driven largely by heterosexual transmission. Over 50 per cent of the Papuan population have not heard of HIV or AIDs and 65 per cent do not know that a condom can prevent its transmission, according to government data from 2007.⁵

The area with the fastest-growing HIV rates

in Papua is Mimika, home to the giant Grasberg copper and gold mine. In 2012 alone, there were 367 new cases recorded in Mimika, reaching a total of 3,190 cases since the first HIV cases were identified in 1996. HIV infection rates are particularly high around mining sites, military bases, ports and other transport hubs, where men come for work and thousands of female sex workers, both Papuan and non-Papuan, have followed.

Many Papuan women live a transient existence, which can make them more vulnerable to infection. According to Jenny Munroe, a researcher at the department of community health sciences at the University of Calgary:

'Men and women get together young ... and the woman is taking care of the household and the children while he is off getting higher education or working. They move around, so many women are in some in-between place, not where they are from, and yet not always with their husband either, as he moves from place to place pursuing opportunities, and starting new sexual/marital relationships in new places. Gender expectations, marital norms and new mobilities are certainly posing challenges for young women in terms of HIV exposure.'

Married women are most at risk for contracting

Left: An indigenous Mooi woman, Papua, Indonesia. *James Morgan/Panos.*

HIV in Papua, according to official data. Papuan women experience a high level of domestic violence. The number of cases of violence against women in Papua was the highest in Indonesia, according to a 2006 national survey.⁶ Papuan women's groups reported an increase in domestic violence after the implementation of the Special Autonomy law of 2001, a provision of which disburses central government funds directly to households. Many Papuan women report their husbands taking the money and spending it on alcohol and sex workers. Women do not feel in a position to demand fidelity or ask their husbands to use condoms, even if they know their partner is infected with HIV.

Papuan women who engage in sex work are at an even higher risk of HIV infection. The industry is stratified by ethnicity; migrants from other parts of Indonesia are the highest paid and work in the relative safety of bars and brothels, Papuans are paid the least and work in the street, increasing the risk to their personal safety. Papuan women sex workers are also less likely to use a condom. In one rural area, an NGO study found that less than 5 per cent of Papuan sex workers used a condom. In comparison, Indonesian sex workers working in larger brothels outside the capital reportedly convinced 70 per cent of their clients to wear a condom.

Such low condom use and knowledge about HIV is a result of poorly targeted HIV education campaigns. For example, 100 per cent condom use campaigns have targeted brothels and bars, where mainly non-Papuans work, but have overlooked Papuans working outside these establishments.

There are also serious barriers for Papuan women to access health care. In Merauke, a town with one of the region's highest number of HIV cases, a government clinic provides free monthly medical check-ups for sex workers. In September 2001, 172 women used the clinic's services. But even though there are around 400 active female Papuan sex workers in the area, only one Papuan woman visited the clinic over a year. Reflecting a widespread tendency to blame Papuan indigenous culture, the clinic director argued that Papuan

women did not visit the clinic because of 'shyness' and their communities' overly 'strong' traditions. Other researchers suggest Papuan women do not know about the services offered or about HIV in general and feel intimidated by using a clinic run by non-Papuans.

Fear of stigma and discrimination

Papuans living with HIV face huge stigma and discrimination from members of their community; as a result many are afraid to be tested for HIV or get treatment. In highland communities, people commonly respond to illness by retreating to the forest to suffer the illness alone without access to care; this reinforces the idea that social withdrawal is an appropriate action. Self-stigma or a sense of shame is also common. Women take great care not to disclose their HIV status for fear it will threaten their relations with their family, especially as their physical well-being decreases.

Many women also do not access the care they need because they are afraid to disclose their status and have feelings of self-stigma. As one Papuan woman noted:

'I'm shy, I'm afraid if anyone knows my status. I heard on the radio that if you have HIV then you will die. So I don't want to tell anyone, I'm afraid. So I pretty much stay home, if anyone sees me they will suspect I have HIV.'

Many women feel judged by non-indigenous health care workers. A survey of health care workers in the highlands of Papua showed that some agreed with discriminatory statements such as that people living with HIV/AIDS are dirty and should be shunned; and most assumed that people living with HIV/AIDS will feel ashamed of their status.

Vietnam

The Vietnamese government collects some health data disaggregated by ethnicity, but only for the five largest minority groups, and not for HIV/AIDS prevalence, which is only collected on the basis of provincial prevalence rates. Vietnam's ethnic minorities comprise about 14.3 per cent of the population. The northern province of Dien Bien is home to 21 ethnic groups and the

majority Kinh here only make up 19 per cent of the population. In 2009 the province had the third highest HIV prevalence rate in the country, nearly three times higher than the national average.⁷

As in the rest of the country, HIV is concentrated among men who inject drugs, but in Dien Bien the HIV prevalence rate among men who inject drugs is twice the national average, reaching 43 per cent. Female sex workers, many of whom are local minorities, have an HIV prevalence rate of 20 per cent, which is the highest in the whole country. Further, HIV rates among women accessing antenatal care services in rural Dien Bien were 10 times higher than the national average, at 2.25 per cent.

People who inject drugs in Dien Bien, all of whom were male, had a significantly greater knowledge of how HIV is transmitted than the female sex workers, according to a report by the Asian Development Bank (ADB) and Vietnam and Laos government research organizations. The researchers attribute this to HIV campaigns that focus heavily on male drug users and which have perpetuated the notion that HIV is mostly the problem of injecting drug users. This tendency has led to what some are calling a 'hidden HIV epidemic' among the women of Vietnam, as many wives of drug users have not been accounted for, especially among minority groups. Most HIV-positive pregnant women and mothers in Vietnam have contracted it through their PWID (people who inject drugs) husbands and learned of their husband's status only after they were married.

Economic reforms in the 1990s increased cross-border trade while also indirectly facilitating heroin trafficking routes. Many minority groups in Vietnam have a history of traditional opium smoking among older men that, since the late 1990s, has turned into injecting heroin among younger men. Wives of men who inject drugs are at an increased risk of HIV, which is especially true of minority groups where high numbers of people inject drugs. In studies conducted in three Black Thai communities in Dien Bien, almost half of all women reported at least one male family member had used or was using heroin; a quarter reported at least one male family member dying from drug use.

Right: A Burmese woman in a safe house for women with HIV, Thailand. *Nic Dunlop/Panos.*

Ethnic minority women are less likely to receive treatment for HIV. This is reflected by their low utilization of antenatal care and health facility delivery services, and lack of knowledge about HIV and its transmission, compared to their Kinh counterparts. According to the World Health Organization (WHO), the disparities in access to health services for marginalized minority women and the social majority actually grew over the period of 2006 to 2010. Ethnic minority women are more likely to give birth at home and maternal mortality among minorities is four times higher than among the majority Kinh. Low use of health services makes it extremely difficult to prevent mother-to-child HIV transmission.

Furthermore, HIV tests are only available at district- or provincial-level health facilities. Many minority women receive antenatal care at community health centres, which do not offer HIV testing. Of those minority women who accessed antenatal services at district- or provincial-level clinics where HIV testing was available, only one-third were actually tested for HIV.

Geographical remoteness is often cited as the reason why minority women do not access health care, but health practices that do not consider the realities of minorities are also a significant barrier. For example, health care staff insist that minority women give birth lying down, rather than in a traditional squatting position, common for many minorities. Husbands are not allowed into the birthing room, as is customary for Black Thais and Hmong. Health attendants are often Kinh and so language poses difficulties for minority women, including for HIV voluntary counselling in provincial hospitals where few staff speak minority languages. Stigma in the health care system also prevents HIV-positive ethnic minority women from accessing services:

'We have to wait for all "normal" patients to be examined and receive then our turns, all remaining as people living with HIV and AIDS, to receive services. Doctors and nurses often treated us with bad-mannered behaviours.'



Borders of Burma and Thailand

The health situations facing ethnic minority and indigenous women from Burma and Thailand have many similarities, stemming from systematic human rights abuses, sporadic or non-existent access to health care, low education levels and few employment opportunities. Women from Burma migrate to Thailand in search of work and better lives, but migration leaves them vulnerable to a wide range of human rights violations; many are undocumented migrants, which leaves them at increased risk of sexual violence and exploitation. Many of Thailand's indigenous peoples still remain without access to citizenship documentation, barring them from access to Thailand's public health and education programmes.

Burma is experiencing a whole host of transformations as it makes moves away from a military-run administration, but according to many working in the ethnic minority areas, these changes have not been seen on the ground.

According to Dr Voravit Suwanvanichkij, a

researcher with Johns Hopkins Bloomberg School of Public Health working on HIV with border minority communities, the situation for Burma's minorities may actually be getting worse:

'Sadly, and ironically, the changes in Burma have resulted in more displacement and even multiple displacements, increasingly as a result of "development" projects that push people off their land. Ceasefires with ethnic-based armies have not resulted yet in a durable peace on the ground, and humanitarian groups still do not have full access to populations most severely affected.'

Decades of conflict, government mismanagement and serious under-spending on health infrastructure have left Burma's minorities with some of the country's worst health outcomes. The Mae Tao Clinic, a health facility on the Thai-Burma border serving people from Burma and its migrating communities, has seen a definitive increase in the rates of HIV in the last

10 years, from around 1 to 2 per cent prevalence rate.

There are no clear statistics on HIV rates among minorities from Burma or Thailand. Estimates coming from Burma are likely to be skewed, as HIV projections are based on very limited data, mostly taken from cities. Very serious problems have been reported on the borders of Kachin and Shan states, where ethnic armies have been in open conflict with the military for decades. Sentinel HIV testing of groups on the Thai–Burma border in the early 2000s has found an HIV prevalence rate among ethnic Shan to be 3 per cent for women and 9 per cent for men. In 1999, Shan migrant workers in Chiang Mai area had prevalence rates of 3.8 per cent for women, and 5.7 for men – double Thai rates at that time. Shan migrants’ rights are particularly at risk as they are not recognized by the Thai government as refugees, as opposed to their Karen and Karrenni counterparts, who have access to refugee camps on the borders.

According to Empower Foundation, a Thailand-based sex workers’ rights organization, for many women from Burma’s ethnic minority groups in bordering states, it is not a question of *if* they will migrate to Thailand, but *when*. Migration is unsafe: many lack identity documents from Burma, as travelling the long distance to the capital Yangon makes little sense. Many rely on human smugglers to try to ensure their safe passage, as women under 25 are not allowed to travel unaccompanied in border areas in Burma, and immigration and police on the Thai side of the border pose threats to their passage.

Once women find work they are paid less in the informal sector under poor working conditions – most often in agriculture, fisheries processing, construction and restaurants – with little freedom of movement. Thailand does have a migrant worker registration programme, which should give opportunities for health care, but many employers do not register employees, or women are not covered by the programme, as is the case for sex workers. Anti-trafficking legislation has only served to pose problems for sex workers as many were not actually trafficked: most of the women interviewed by Empower consented to their work. Women are imprisoned

for long periods of time under the law and eventually deported. Many are returned to areas plagued by conflict, areas known for abuses and systemic rape by Burma government forces against minority women.

Minority women from Burma and Thailand are at acute risk of HIV infection because of their engagement in low-end sex work with men who refuse to wear condoms, because Thai-language HIV campaigns do not reach them and because they have no access to health care and fear of seeking out health care services. Further, anti-retroviral (ARV) medication is hard to access: ‘In Thailand, for Thai women, there is universal health care and ARV,’ an Empower staff member notes, ‘but for undocumented migrants from Burma, they have no right to the health care. And they can’t go home to receive treatment either. You can’t carry your bed home ...’

‘The most marginalized are invisible. We don’t see them’, Dr Voravit

Looking at the situations of minority and indigenous women in Papua, Indonesia, Vietnam and Burma, there is a clear set of risks that make these women particularly vulnerable to HIV and, without access to health care, vulnerable to developing AIDS. But minority and indigenous women are largely overlooked by HIV prevention and care efforts because of their marginalized position. They are economically disadvantaged, with low education levels, low ability in the language of the majority, and face discrimination as women within their communities and discrimination from the wider society because of their minority or indigenous status.

With prevalence rates in some minority and indigenous areas reaching generalized epidemics, states and international agencies can no longer ignore the issues and must address the needs of these communities. What follows are some examples of initiatives that have successfully reached out to minority and indigenous populations, including women, for HIV prevention and treatment.

Klinik Kalvary: Indigenous-led community health clinic in Papua, Indonesia

Klinik Kalvary, a community health clinic started

by an American doctor, works in Wamena, Papua Indonesia. It is a grassroots organization, and all of its 20 staff are indigenous Papuans. When it first opened in 2006, they were overrun by indigenous clients wanting to get tested for HIV who had been too afraid to go to the hospital or other voluntary counselling and testing sites.

According to Marcel Kooijmans, who works at the clinic, the indigenous staff make all the decisions and are in charge of all of the programmes:

'They know the culture and also speak the local languages. We use contextualized examples to explain diseases such as HIV/AIDS. Women are still difficult to reach, so we are now developing programmes to specifically reach the women.'

The services of the clinic are available to everyone, but most of the patients are indigenous Papuans.

The clinic specializes in sexually transmitted diseases, tuberculosis, malaria and HIV/AIDS. It also researches ways to make services more accessible to Papuans, and advocates for a better health care system throughout Papua.

While the clinic offers free HIV testing and ARV treatment, it still faces funding shortages. 'We work together with NGOs who teach the local community,' Marcel explained:

'We go out with a testing team to places in the inlands [highlands]. Before we go, the people are taught about HIV and we always take counsellors with us. Before testing in and outside the clinic people get information about the test and HIV. Patients come back every month for check up and more information.'

The clinic also trains indigenous nurses for one year, who then go to work or open other clinics. They train people to live in the villages and directly care for and monitor those affected with HIV, and bring them to the Klinik for further help if needed.

'In everything we do we connect with the indigenous people. The local people know that our staff is local too and that is one of the reasons they like to come.'

The Sunflower Network: Peer support for ethnic minority women in Vietnam

The Sunflower Network started as a small group of HIV-positive women in Hanoi in 2004. It has since grown into a countrywide network of peer support groups, covering seven provinces with over 2,500 members. The network was initially supported by the Medical Committee Netherlands-Vietnam (MCNV). In 2009, groups were established in rural areas with high numbers of ethnic minorities, such as Dien Bien, recognizing the need for peer support among ethnic minority women.

The Sunflower Network's main objective is to improve the quality of life of pregnant women and mothers living with HIV, their children and families, by improving access to HIV treatment and providing information about HIV and its treatment to women, especially young women. The groups also work with national-, provincial- and district-level agencies to improve their understanding of the illness, and address stigma attached to people living with HIV/AIDS and the specific issues faced by women. Mobile voluntary counselling and testing clinics for pregnant women in rural minority areas has also been a key part of the network's work.

MCNV project manager Ian Brommage reflected on the project:

'The aim of this work is to help empower these women to advocate for their rights, ensure they have access to services and are able to live in their communities free from stigma and discrimination.'

In Dien Bien the Sunflower Network has established three project sites, with 212 members, many from the Black Thai community. As a result communities have seen improvements in mental health, improved access to services and knowledge of sexual and reproductive health. A recent evaluation concluded that stigma and discrimination against minority women with HIV/AIDS had decreased in health care and education, as well as from within their families and communities. This has been brought about through support to individual minority women with HIV/AIDS suffering stigma, as well as by organizing community events, which have helped

to strengthen their self-esteem and increase awareness more generally.

The Sunflower Network continues as a positive example of women peer support groups, and has resulted in spin-off groups, such as the Cactus-Blossom group for female injecting drug users.

Community radio drama spreads public health information in the Mekong region

'While good information does not guarantee good choices, no information virtually guarantees bad choices.' David Feingold, former UNESCO project manager

The key problem in providing effective HIV prevention among minority communities in South East Asia is that minorities receive virtually no HIV prevention information in their own language, according to David Feingold, former UNESCO programme manager. Between 2001 and 2011, UNESCO, with support from the ADB, undertook a project to disseminate HIV prevention information in minority languages throughout the Greater Mekong Subregion (GMS), which covers Cambodia, China, Laos and Thailand. UNESCO developed radio dramas to broadcast culturally appropriate information about HIV prevention in minority languages on local stations. In China, for example, the little HIV prevention material that was available in local languages had previously been directly translated from materials developed in Beijing. Characters were set in an urban context, using words and sayings relevant to a Han Chinese target audience; the cultural cues and signs inherent in the message were lost on minority populations.

In contrast, UNESCO developed a way of using storytelling to disseminate HIV information. Episodes were based on research undertaken in the communities, to develop believable storylines. Often storylines were written by a team of story writers from the minority community, or, when this was not possible, authors who were native speakers of the minority language. Dramas were then written in the minority language, rather than translated from Mandarin. After that, the minority language script was translated into the majority language

or English to double-check the accuracy of the health information. Programmes were then tried out with the local community to receive their feedback.

UNESCO's project is the only one of its kind that has addressed the issue from a regional perspective, understanding that the issue of HIV is very much a cross-border problem, particularly in the GMS. In total, the project covered 13 minority languages, and two were turned into television dramas.

'Women from minority groups are less likely to have good control of the national language, so this was one of the best ways to specifically engage minority women,' Feingold concluded.

Recommendations

International organizations and all levels of government must:

- acknowledge that women from indigenous and minority communities are vulnerable to contracting HIV/AIDS and experience significant barriers to receiving effective health care;
- collect data disaggregated by ethnicity and gender to target health initiatives toward the most vulnerable groups;
- acknowledge and remedy inequalities in access to health care, and incorporate a broader view of the multiple forms of discrimination faced by indigenous and minority women, and consider the role of men in preventing transmission among their partners and children;
- incorporate indigenous and minority women's voices, values and ideas into policy-making and programmes for HIV prevention and treatment;
- support grassroots initiatives that address the needs of minority and indigenous women;
- develop culturally appropriate material to raise awareness about HIV prevention in minority languages that is gender sensitive and targeted toward women; and
- prioritize education and training for indigenous and minority women health care workers, fostering full participation in health care administration and policy development. ■

Endnotes

1. Munro, J. and Butt, L. (2012) 'Compelling evidence: research methods, HIV/AIDS, and politics in Papua, Indonesia', *Asia Pacific Journal of Anthropology*, vol. 13, no. 4, 2012, pp. 334–51, retrieved June 2013, <http://dx.doi.org/10.1080/14442213.2012.694467>. Papua here refers to both Papua and West Papua, Indonesia.
2. Excerpt from Documentation Working Group, *Enough Is Enough! Testimonies of Papuan Women Victims of Violence and Human Rights Violations 1963–2009*, retrieved June 2013, http://ictj.org/sites/default/files/ICTJ-IDN-Enough-Women_Papua-Report-2010.pdf
3. Simonin, A., 'Social, cultural and political factors in the design of HIV programmes with Papuan highland communities', *Culture, Health & Sexuality: An International Journal for Research, Intervention and Care*, vol. 13, suppl. 2, 2011.
4. See: Butt, L. et al., *Stigma and HIV/AIDS in Highlands Papua*, retrieved July 2013, <http://www.papuaweb.org/dlib/tema/hiv-aids/butt-morin-et-al-2010-stigma-HIV.pdf>
5. Simonin, *op. cit.*
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Mental health care for survivors of torture and conflict

David Gangsei, Erin Morgan, Paul Orieny,
Ann Willhoite, Holly Ziemer

It is estimated that between 5 and 35 per cent of today's refugees are survivors of torture. Research by the Center for Victims of Torture (CVT) has found that rates are much higher in some specific refugee populations: 69 per cent of men and 37 per cent of women from Oromo refugees resettled in Minnesota in the US have been tortured; 37 per cent of women and 25 per cent of men in the Somali refugee community have experienced torture.¹

While each conflict has its own story of origin, the violence is distressingly familiar: forced recruitment of children and adults as soldiers; arbitrary arrests, detention and torture; sexual crimes against men, women and children; barbaric rape of women and girls leaving some with extreme and irreparable mutilation; witnessing killings or being forced to kill; kidnapping and human trafficking.

Many survivors rebuild their lives with supportive families and communities. But a significant number will face serious, ongoing symptoms as a result of their torture and war experience. Survivors can live with constant fear, debilitating depression, terrifying nightmares, crippling anxiety and thoughts of suicide. These symptoms can be incapacitating, leaving survivors unable to care for themselves or their families the way they could before.

The Center for Victims of Torture (CVT) is an international non-profit organization dedicated to healing survivors of torture and war. It provides direct care to survivors at its healing centre in Minnesota and at healing initiatives in Africa and the Middle East.

While CVT is one of the largest torture rehabilitation centres in the world, its ability to provide mental health care in a refugee camp or post-conflict nation is overwhelmed by the scale of violence and numbers of survivors. In response to this overwhelming global need, CVT has developed community mental health programmes to provide direct services to those most deeply affected and to develop the capacity of local communities to meet their own mental health needs.

The heart of CVT's international mental health initiatives is training. The training is experiential, with paraprofessional counsellors – recruited from affected communities where

possible – learning alongside professional psychotherapists with survivors in individual and group settings.

Peer counsellors undergo an intensive training period and then receive monthly formal trainings and ongoing feedback. CVT always aims to build sustainable healing services for torture survivors. Therefore, training for counsellors is lengthy, hands-on and intensive.

At the community level, CVT conducts large-group activities to raise awareness of the prevalence and effects of torture. Staff work together with teachers, religious figures and other community leaders to identify how they can help others, address community-level conflicts, form a supportive community for healing and identify individuals who might benefit from care.

CVT's collaboration with the community and training of paraprofessional psychosocial counsellors also aim to carefully incorporate positive cultural systems and rituals into evidence-based mental health interventions.

Dadaab, Kenya

In 2011, CVT began to use this model for care and training to provide mental health services in one of the refugee camps located outside Dadaab, Kenya.

The Dadaab refugee complex in north-east Kenya is the world's largest refugee site. The area is dry and dusty, with temperatures usually above 40 degrees Celsius. The sprawling camps are notorious for overcrowding. Designed to house 90,000, they are home to over 460,000 refugees.

In Dadaab the organization provides care for a population of refugees who are primarily from Somalia. Although some humanitarian groups were attempting to address mental health needs, CVT was the first mental health-focused organization to work in the camp since it was built in 1991.

Experience in Dadaab shows that torture and violence among civilian populations in Somalia was widespread and indiscriminate. Many survivors have withstood a number of different traumatic events, including persecution of minority clans by majority clans, and violence by the armed Islamist organization al-Shabaab and the government.

CVT bears witness within the Dadaab camps



to discrimination, harassment and even assault towards minority populations. Most refugees in the camps are from the Somali majority but there are Somali minority groups including Bantu, Benadiri and occupational groups. There is also a small number of refugees from other African countries, including Burundi, the Democratic Republic of Congo, Eritrea, Ethiopia, Rwanda and Sudan.

The stigma assigned to people with mental and physical illness is staggering. In some cases, survivors the camps serve have been ridiculed, harassed and even stoned for having a physical or mental disorder related to their traumatic experiences. Members of minorities who also suffer mental and physical illness face double discrimination.

Women and girls from minority groups are particularly vulnerable in the camps. They are harassed when they go to the market if they are not dressed as the majority group. No female can expect to wear skirts, trousers or uncovered hair without attracting verbal and often physical harassment. Other women have reported that

they were not allowed to fetch water or to queue at water points. Efforts are made to prevent women from gathering firewood in the town, so that majority groups can sell the wood for profit.

In 2013, a woman from a minority community was raped and there was suspicion that it was an attempt to intimidate her community and discourage them from taking jobs from the majority. Rape in the Dadaab camps is a common occurrence, with women and children being the most vulnerable to this violence.

Others report that individuals from the majority communities are more likely to be offered employment, and that minority group members are provided with fewer food rations at distribution centres where majority groups are employed and responsible for handing out the rations.

Language is another significant barrier. Since most translators in the camps are from majority groups, this prevents minority groups from interacting and claiming their rights within the camps. This happens when shelter, resettlement or other materials are offered by humanitarian

Left: The Ifo Extension refugee camp in Dadaab, near the Kenya-Somalia border. *REUTERS/Thomas Mukoya.*

groups and the UN refugee agency.

The tenuous security situation in the camps compounds the difficulties of vulnerable groups. One paraprofessional counsellor who had a physical disability was able to work at CVT because a CVT vehicle could transport her to the counselling compound. After attacks on refugee leaders and the kidnapping of aid workers, organizations could not enter the camps except for their own compounds. Unable to get transportation or to walk 5 km, the counsellor was not able to continue working.

Cultural norms also prevent the camps from hiring as diverse a staff as they intend. In Dadaab, it has been difficult for the camps to hire the number of women counsellors they would like to, since the majority culture puts the responsibility of care for the family and children above work outside the home.

At times, not finding translators means survivors seeking our services need to wait before they can receive counselling. While we make every effort to find and train interpreters, limited access to the camps combined with extremely limited resources mean there can be a waiting period.

Minorities who received supportive mental health services from CVT report that they have found a refuge where they can gather strength and courage to withstand the prejudice they cannot escape in the camps. Survivors receiving services from CVT in Dadaab consistently report significant decreases in mental health symptoms such as anxiety and depression, as well as decreases in somatic symptoms. They report increased hope, better coping skills and improved relationships.

Rehabilitative care for minority groups

For minority groups, equal access to mental health care is necessary to rebuild lives and community, and to establish a voice that can advocate for their own rights among the majority population. Unfortunately, the need for mental health care far exceeds available services. CVT

and other organizations focusing on mental health are able to provide care to only a fraction of the survivors in need.

Integrating mental health services along with capacity building is one way to scale up care for survivors after conflict and political violence. The paraprofessional psychosocial counsellors employed by CVT gain several years of education, training and direct clinical work. They are ready to serve, but there are no complementary mechanisms in place to support their long-term development to continue this work.

The well-being of traumatized individuals and communities requires both access to mental health services and building of local capacity to provide those services. Counsellors representing minority groups should be an integral part of the process. With experience and training, they can continue to provide care in culturally appropriate ways to members of their community, act as educators about the effects of trauma and participate in the development of community-based approaches to addressing the needs of the community, including pursuit of basic human rights, health and education.

It is understandable that humanitarian aid during and after conflict is focused on basic needs: food, clean water, shelter and medical care. It is also essential to integrate mental health care in support of refugees and during post-conflict rebuilding. When political violence intentionally destroys a community, the society itself must heal before peace and civil society can grow. ■

Endnotes

1. Jaranson, J.M., Butcher, J., Halcon, L., Johnson, D.R., Robertson, C., Savik, K. et al., 'Somali and Oromo refugees: correlates of torture and trauma history', *American Journal of Public Health*, vol. 94, no. 4, 2004, pp. 591–8. Retrieved June 2013, <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1448304/>

Litigating the right to health for indigenous peoples

Carla Clarke

The Xakmok Kasek indigenous community lives in the Chaco region of Paraguay. Over a lengthy period they had been restricted to occupying an ever diminishing area of their traditional lands and even then it was at the whim of the private ranch owners, who forbade them to hunt, keep livestock or cultivate their own crops. Having failed to secure recognition of their land rights through the national process during the 1990s, the community started legal proceedings at the regional level in 2001 and in 2010, the Inter-American Court of Human Rights (IACtHR) found in their favour and ordered that Paraguay return their lands to them. The Xakmok Kasek thus joined with a growing number of other communities, including the Awas Tingni of Nicaragua and the Yakye Axa and Sawhoyamaxa indigenous communities, also from the Paraguayan Chaco, in invoking the right to property to secure recognition of their rights to their traditional lands (even if implementation of such favourable decisions often remains wanting).

As well as the right to property, in the case of the Xakmok Kasek community, the IACtHR was asked to examine the issue of provision of basic services, including health services, with respect to the obligation on the state to protect the right to life (interpreted as the right to a decent existence). Given that in 2009 the government of Paraguay had itself declared a local state of emergency on account of the community's precarious and vulnerable situation due in part to the absence of medical care, it is not surprising that the IACtHR found a violation of this right. Specifically, the IACtHR found that the state had not guaranteed physical or geographical access to health care establishments for the community (the nearest health care centre was 75 km away, poorly run and had no vehicle that could reach the community, while the nearest hospital was over 400 km away and the public bus fare there was out of the reach of the members of the community). Similarly, the Court found that the state had not taken any measures to ensure that the medical care and supplies would be acceptable, taking into account traditional practices. The Court therefore went on to order that until their traditional lands were returned: (1) immediate medical attention

was to be provided to the community; (2) given the difficulty of members of the community in accessing health clinics, a permanent health clinic was to be established where they were currently settled, and with the necessary medicines and supplies; and (3) a system of communication was to be established between the community's settlement and competent health care authorities for emergency cases, and, if necessary, transport was to be provided by the state for such cases. Once the community resettled on their traditional lands, both the medical centre and the communication system were to be moved there. The IACtHR also attributed a number of deaths of members of the community (predominantly children) from such preventable illnesses as pneumonia, tetanus, anaemia and dehydration to the state due to the lack of medical attention provided.

Given the fundamental relationship of indigenous peoples to their lands and resources, and that many indigenous communities either find themselves already displaced from those lands or in situations where their lands are being encroached upon without their consent by third parties (e.g. for logging, oil exploitation or the establishment of wildlife reserves), it is not surprising that where indigenous communities have been able to overcome the numerous obstacles to accessing justice it is primarily in order to claim their right to their traditional lands. Even in cases where violations of their right to health are not directly pleaded in addition to their right to property (as in *Xakmok Yasek* but also in *Yakye Axa* and *Sawhoyamaxa*), it can be argued that in securing recognition of their rights to their traditional lands they are also securing recognition of the principal underlying determinants included in their right to health. This interplay between health and secure rights over indigenous traditional lands has been recognized at the international level.¹

There have been some cases brought by indigenous peoples where health has been the primary focus, but where their submissions have emphasized the negative impact on health through spoliation of traditional lands. Such cases include *Mapuche Paynemil and Kaxipayiñ Communities v. Argentina* before the Inter-American Commission on Human Rights



(IACHR) concerning contamination of water on indigenous land with lead and mercury affecting community health, particularly that of the children; and *The Social and Economic Rights Action Centre and the Centre for Economic and Social Rights v. Nigeria* before the African Commission on Human and Peoples' Rights concerning the Ogoni and the negative health and environmental impacts of oil exploration in Ogoniland. At the national level, the case brought by the San of the Central Kalahari Game Reserve challenged a decision of the Botswana government to terminate essential services such as the provision of mobile health clinics in what was an attempt to force them off their traditional lands.

One of the few cases concerning the right to health of an indigenous people in the absence of

a property connection is that of *María Mamérita Mestanza Chávez v. Peru* before the IAHCR. Rather than being about the failure of the state to provide accessible and adequate health care, the case concerned the provision of unwanted health services, namely the forced sterilization of generally poor, rural and indigenous women as part of a government policy to change the reproductive behaviour of the population.

While the focus on litigating over indigenous peoples' property rights is understandable, the dearth of litigation on the right to health, absent a territorial connection, both at regional and national level, calls for further examination, given that report after report, study after study shows that indigenous peoples suffer from higher mortality and morbidity rates than non-indigenous populations. For example, while

Left: Bodo community villagers point to an oil spillage site in a river in the Ogoni region of the Niger Delta, Nigeria. *REUTERS/Akintunde Akinleye.*

Guatemala has already surpassed the MDG 4 target of reducing childhood mortality by two-thirds in relation to non-indigenous children, it has yet to reach it in relation to indigenous children. The gap between the mortality rates of indigenous and non-indigenous children has remained more or less constant since the base year of 1987. Even in Brazil, where a specific Indigenous Health Subsystem has existed since 1999, early improvements in indigenous health indicators have since stalled such that, despite significant expenditure, they continue to have the worst health status of any group. (See the regional chapters for other examples.)

The situation also calls for further examination given the fact that, in a region such as Latin America, activism among indigenous peoples is arguably more organized and their rights, at least in theory, are better protected (e.g. under Paraguay domestic legislation, indigenous people are entitled to free medical services) than in other regions. One key regional trend has been the exponential growth in the last two decades of the right to health litigation among the non-indigenous population, with a high rate of both success and implementation. However, not only have indigenous people not benefited from this growth, they are arguably further prejudiced by it as finite health care budgets are used on providing the medications ordered by the courts, since the litigation is, by and large, around access to (often costly) medication. An increasing number of commentators call into question the individual nature of the increase in the right to health litigation. The time appears ripe for a case to be brought which is about structural access to health care and systematic provision of essential services so that the right to health of the most vulnerable becomes a reality.

In this regard, hope can perhaps be taken from action by treaty monitoring bodies. In a relatively recent case before the UN Committee on the Elimination of Discrimination Against Women (CEDAW) concerning an Afro-Brazilian woman who died due to lack of adequate emergency

obstetric care, it was alleged that access to quality medical care during pregnancy was a systematic problem. In finding against Brazil, including finding that the woman had been discriminated against because of her ethnic status, CEDAW recommended that Brazil ensure affordable access for *all* women to adequate emergency obstetric care (*Alyne da Silva Pimentel v. Brazil*, 2011).

Litigation may not be a complete panacea but, on current trends, without judicial intervention it is difficult to see substantial progress being made in realizing the right to health for indigenous communities. ■

Endnotes

1. See the UN Committee on Economic, Social and Cultural Rights' General Comment no.14, para. 27.



ATLANTIC
OCEAN

INDIAN
OCEAN

MADAGASCAR

TUNISIA

MOROCCO

ALGERIA

LIBYA

EGYPT

Western
Sahara

MAURITANIA

MALI

NIGER

ERITREA

SENEGAL

THE GAMBIA

GUINEA-BISSAU

GUINEA

BURKINA
FASO

CHAD

SUDAN

DJIBOUTI

SIERRA
LEONE

CÔTE
D'IVOIRE

GHANA

BENIN

TOGO

NIGERIA

CENTRAL
AFRICAN REP.

SOUTH SUDAN

ETHIOPIA

LIBERIA

CAMEROON

SAO TOME
AND PRINCIPE

EQUAT.
GUINEA

GABON

REP. OF
THE
CONGO

DEM. REP.
OF THE CONGO

UGANDA

KENYA

SOMALIA

RWANDA

BURUNDI

TANZANIA

ANGOLA

ZAMBIA

MALAWI

MOZAMBIQUE

NAMIBIA

BOTSWANA

ZIMBABWE

SWAZILAND

LESOTHO

SOUTH AFRICA

Africa

Paige Jennings, Inga Thiemann,
Laura A. Young

East Africa

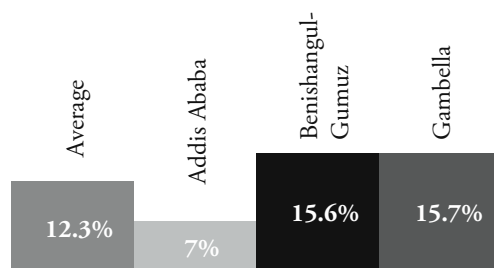
Laura A. Young

Against a background of famine and conflict in 2011, the year 2012 brought new hope for increased stability and regional coordination in East Africa. The region emerged from a devastating drought, which had created health and humanitarian emergencies in several countries. Regional intervention in Somalia reached a peak in 2012, as Ethiopia, Kenya and Uganda all sent troops to the country. From a health perspective, these changes brought a new opportunity for progress. Across East Africa there have been strong gains in maternal and child health – fewer mothers are dying in childbirth and more children are surviving beyond infancy. For instance, Ethiopia’s rate of maternal mortality has steadily declined over the past 20 years. But for minority and indigenous peoples, these gains have been unequally realized because of ongoing marginalization. Lack of transportation infrastructure to access health centres, poverty that makes paying for care almost impossible, and discrimination related to the provision of health services often prevent minority groups from benefiting from general gains at the national level. Also, disaggregated health data on minority groups is often unavailable or difficult to access, making targeted intervention and planning a challenge.

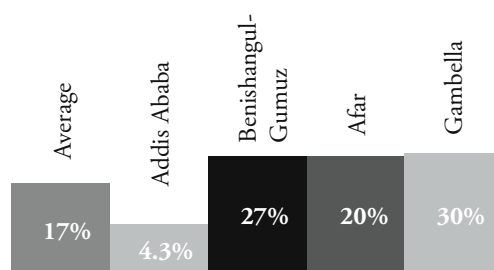
Ethiopia

Ethiopia has made positive gains in health care indicators over the past decades, consistent with the trend in East Africa generally. Both maternal and child mortality have reduced, and the government has been lauded for its commitment to training community health workers, especially women, to assist with basic health needs. However, substantial challenges remain, including maternal mortality, malaria, tuberculosis and HIV/AIDS, compounded by acute malnutrition and lack of access to clean

water and sanitation. The limited number of health institutions, disparity between rural and urban areas and severe under-funding of the health sector all make access to health services very difficult. It is estimated that more than half of Ethiopia’s population lives more than 10 km from the nearest health facility, often in regions with poor transportation infrastructure. Another major issue in the Ethiopian health sector is brain drain – there currently are more Ethiopian doctors working in Chicago, USA than in Ethiopia according to some experts.¹



Under-five mortality rate in Ethiopia



Teenage girls between 15 and 19 years of age who have been pregnant in Ethiopia

But for many minorities and indigenous peoples in Ethiopia, health concerns are exacerbated. Although health data in Ethiopia is rarely disaggregated by ethnicity, regional data provides some insights, given the residency patterns of minority groups. Reports indicate that many negative health indicators are above the national average in federal regions populated predominantly by minority groups, such as Gambella, Afar, Oromia, Somali region, Benishangul-Gumuz, and the Southern Nations, Nationalities and Peoples (SNNP) region. For instance, while the under-five mortality rate

in Addis Ababa is 72 per 1,000, the rates in Benishangul-Gumuz and Gambella are 156 and 157 per 1,000 respectively; the national average is 123 per 1,000.² The percentage of teenage girls between 15 and 19 years of age who have been pregnant is 4.3 per cent in Addis Ababa, but is 20 per cent in Afar, 27 per cent in Benishangul-Gumuz and 30 per cent in Gambella – the national average is 17 per cent.³ Early pregnancy is a major risk factor for other health problems, including obstetric fistula (see case study on p. 68). Distribution of health care infrastructure is also uneven. According to the Ministry of Health, Addis Ababa has 33 hospitals for a population of 3.1 million, whereas Afar region has two hospitals for a population of 1.5 million, Somali region has eight hospitals for a population of 4.5 million, and SNNP region has 20 hospitals for a population of almost 16 million.

A substantial proportion of minority groups and indigenous peoples in Ethiopia are pastoralists. Pastoralism brings unique health challenges, especially for women. As reflected in the statistics above, pastoralists who live in rural, low population density areas often must travel long distances to access health services.

Gender disparity in health indicators also is heightened – for instance, men outlive women in pastoralist areas, the inverse of national data. This disparity may be a result of the intensive household work burdens put on pastoralist women as well as clear boy-child preferences in pastoralist communities. Harmful practices such as female genital mutilation (FGM) and early marriage, as well as chronic malnutrition, also contribute to lower health status among pastoralist women.

On 20 August 2012 the government announced that Prime Minister Meles Zenawi had died after governing for 21 years. Under Meles, Ethiopia became one of Africa's largest recipients of foreign donor aid, including health aid, receiving more than US\$3 billion total aid in 2010 for example. Despite this, the health system remained chronically underfunded.

Ethiopia's progressive Constitution is protective of minority rights, with a system of ethnic federalism that protects the right to self-determination. However, under Meles the system was never truly implemented. Instead, Ethiopia

remains a nation of centralized decision-making and minimal democratic space. After Meles' death, his deputy, Hailemariam Desalegn was quickly elevated to acting head of government.

Desalegn is not expected to preside over any substantial change in Meles' policies. For example, controversial villagization schemes continued in five regions of Ethiopia in 2012. The villagization programme, resulting in forced resettlement of tens of thousands of people, has had serious negative impacts on minorities and indigenous peoples in Ethiopia. Although the asserted purpose of the villagization process is to provide enhanced public services, including health care, relocated Ethiopians report that the promised services have not materialized. Severe negative health consequences, including starvation and malnutrition, have resulted from the lack of arable land, and those who resist relocation report beatings, arbitrary detention and even killings as a result of their resistance. In Ethiopia's Gambella region, the indigenous Anuak community was so negatively affected by the programme that in 2012 it brought a complaint to the World Bank's Inspection Panel, claiming that the US\$1.4 billion that the World Bank had provided to the Ethiopian government in support of the programme was contributing to massive human rights abuses.

Kenya

Preparations and campaigning for the 2013 elections dominated life in Kenya for much of the year 2012. During the first political campaigns since the adoption of a new Constitution in 2010, Kenyan minorities and indigenous peoples struggled to find their voice in the new political landscape. The delineation of electoral boundaries was contested by many communities in Kenya, including minorities and indigenous groups. The multiple petitions were consolidated in a single, large case that was decided by the Kenyan courts in 2012. In many cases, the court took account of minority interests in addressing boundaries and redrew electoral units to afford minority groups a chance to have a member of their community elected either at the local or parliamentary level. However, civic education to ensure that minority and indigenous communities understood new political structures

and were well-prepared to vote in the election remained a concern in 2012. Smaller indigenous communities, and indigenous women in particular, reported a low level of understanding of the new Constitution, despite important provisions in the Constitution that protect the rights of minorities and indigenous peoples.

The presidential campaign was dominated by candidates from the two largest ethnic communities in Kenya. Ultimately Uhuru Kenyatta, son of Kenya's first President and a member of the Kikuyu ethnic community, was declared the winner. Ethnically aligned politicking and the formation of political alliances based on large ethnic blocks left less room for minority groups, especially very small communities, to wield influence at this level. Candidates from minority and indigenous groups did, however, emerge in many areas to contest for elective office. In particular, the constitutionally reserved women's parliamentary seats opened opportunities for women from minority and indigenous communities to contest for office. MRG documented women candidates from the El Molo, Maasai, Pokot, Rendille and Somali communities, among others, contesting for 'women representative' seats in their respective regions. MRG partner organizations nevertheless reported that at least some minority and indigenous communities saw their representation decrease at the local and national levels.

The right to health is protected in Kenya's 2010 Constitution and provides that all Kenyans have the right to the highest attainable standard of health, including health care services. Despite this guarantee, minorities and indigenous peoples in Kenya face substantial challenges, including lack of physical and financial access to care as well as discrimination.

A major complaint from many in Kenya, especially those in marginalized areas, is that health personnel are only rarely present in health centres. Community members report arriving at health centres with serious, urgent conditions only to have to wait for days because no health care staff are available. For example, a human rights monitor in the Ogiek community, which lives in remote regions in and around the Mau Forest, reported that community members who can find transport to the nearest health centre

are often told to return another day. In early 2012, thousands of health workers in government health facilities around the country went on strike over pay and benefits. The strike left patients unattended and some died as a result of lack of care. The government threatened to fire 25,000 of the strikers after they ignored demands to return to work. Ultimately, the strike was resolved when Prime Minister Raila Odinga finally agreed to meet the strikers' representatives and address some of their demands. The end of the strike, however, did not resolve the underlying challenges in Kenya's health sector. For minority groups, marginalization, poverty and displacement all contribute to an inability to realize the right to health. Decades of marginalization in many areas have left roads non-existent or impassable during rains. Government-run health centres remain understaffed and often without essential supplies and medicines. Kenya's constitutionally mandated Equalization Fund is designed to help remedy these disparities, specifically to raise the level of basic service provision – including water, roads, health facilities and electricity – in marginalized areas. However, legislation to implement the fund has not yet been drafted and initial government proposals on how 'marginalized areas' would be defined for the purposes of the fund would leave many minority and indigenous communities without any access to equalization resources. Land loss and displacement has also deepened poverty in many minority communities, to the extent that the financial cost of health care can be a major burden. For instance, Sanye community members, who reside in the interior coastal regions of Lamu County, report that no one in the community has sufficient resources to pay the fees charged by health centres, so they use traditional medicine or someone outside the community must pay for health care costs.

Another serious, yet under-analysed, health concern in minority communities is the effect of violence – including deaths, serious injury, long-term disability and reduced quality of life, as well as psychological trauma. Kenya's Coast region, home to several ethnic minority and indigenous communities as well as many members of Kenya's minority Muslim community, was a

particular flashpoint in 2012. In August 2012, a well-known Muslim cleric was executed in Mombasa leading to deadly and destructive rioting; five people were killed and churches were attacked. In the Tana River region, hundreds of Kenyans including civilians and members of the security forces were killed in a series of massacres and revenge raids that pitted ethnic Pokomo agriculturalists against Orma pastoralists. In December 2012, simmering conflict between Turkana and Samburu pastoralists resulted in the killing of 42 Kenyan police officers, who were in the midst of an operation to recover cattle, in the Baragoi region. The government's response to the attack on the police led to the displacement of hundreds of families from the area. While deaths are the most often reported tragic outcome of this violence, many communities live with permanent scars, both physical and emotional. Often the long-term trauma is disproportionately borne by women. The director of the Consortium for the Empowerment and Development of Marginalized Communities (CEDMAC) identified the health and psychological consequences of violence as the top issue facing minority and indigenous women in Kenya.

Finally, minority and indigenous communities continued to confront threats to access and control over their land and natural resources. Land loss and displacement have negative health consequences through entrenching poverty and reducing communities' ability to gather and use traditional healing products. In many instances, displacement is for the purpose of development, which in Kenya has often led to environmental degradation and resulting food insecurity. In March 2012, the Kenyan government announced the discovery of oil in Turkana County. The discovery of oil has led to extensive exploration around Lake Turkana, a major environmental asset for Turkana and other minority groups such as the Rendille and El Molo, who fish and hunt animals that live near the lake. Communities in the region fear environmental changes for Lake Turkana as a result of oil exploration in Kenya and the Gibe III dam project in Ethiopia. On the Kenyan coast, multiple minority and indigenous groups continued to oppose the construction of the Lamu Port, which was officially launched in March 2012. The Save Lamu Coalition filed a

case in a Kenyan court in 2012 to stop the port project. The port is anticipated to have severe negative environmental impacts for the Aweri, Bajuni, Orma, Sanye and other communities through loss of fishing grounds and traditional lands.

The Endorois community continued to advocate for implementation of a 2010 decision of the African Commission on Human and Peoples' Rights (ACHPR) that recommended that the government compensate them for eviction and loss of access to their ancestral lands; however there had been no significant steps towards implementation by the government before the end of 2012. The Ogiek land rights case was referred by the ACHPR to the African Court on Human and Peoples' Rights in 2012; it will be the first case on indigenous peoples' rights to be considered by the court (see case study on p. 61).

Somalia

Somalia emerged into a new political era in 2012, with substantial hope for improvement in the lives of Somalis, including the health status of the population. Military intervention, including African Union peacekeepers (AMISOM), Kenyan forces and Ethiopian troops, continued in 2012 and succeeded in pushing al-Shabaab out of several key areas, including Kismayo and Mogadishu. As the military operation moved forward, the process of designing a new constitution and new institutions of governance continued on a parallel track. The first formal Somali parliament was sworn in in August 2012 and the parliament voted in September to elect Hassan Sheikh Mohamud as president. As new governance arrangements were concluded, however, concerns remained that minority groups such as Bajuni, lower caste Midgan and Somali Bantus, as well as women were not sufficiently represented in the arrangements, a problem that has undermined previous governments. The perpetuation of marginalization into the new dispensation in Somalia raises concerns for minority rights in general in Somalia, including the right to health.

Although data on minority and indigenous communities in Somalia are difficult to obtain, in general, minorities experience more challenges



Above: A Bantu family home in Somalia.
Petternik Wiggers/Panos.

in accessing health care and thus experience more negative health consequences. A UN OCHA (Office for the Coordination of Humanitarian Affairs) study identified several challenges related to access to health for minorities in Somalia:

- Conflict and insecurity makes it difficult for aid agencies to access vulnerable communities.
- There is a lack of adequate information regarding the health status of minority groups.
- There is a lack of adequate transport infrastructure, including land routes and water routes.
- There are insufficient numbers of health centres, including mother and child health services and tuberculosis clinics, in minority areas.
- Minorities in urban areas observe that their concerns are not given much consideration when establishing health centres. They say that local authority staff do not report serious health conditions in Dami and Gaan Libah, where many minorities reside.

Despite the positive political developments and enhanced security, many of these problems remain for minority communities.

However, there also are positive indicators in Somalia's health sector. The drought-induced famine in Somalia was officially declared at an end by the UN in February 2012. The ending of al-Shabaab occupation in many areas has enabled the government and its international partners to enhance health services. New health centres have opened and are offering service to approximately 1 million Somalis. Vaccination campaigns were conducted in 14 districts of southern and central Somalia between November and January for the

first time in four years, inoculating more than 383,000 children under the age of five against polio and almost 80,000 against measles. Another campaign to provide health and nutrition services, including vaccines, reached about 275,000 children and 394,000 women in 26 districts in December. Despite this, cholera outbreaks in 2012 demonstrate the challenging health situation in many parts of Somalia. The World Health Organization (WHO) estimates that there are about 215,000 children who remain malnourished and at risk of complications from malnutrition.

In the past, minority groups in Somalia have faced substantial health challenges – they have been among the most vulnerable of groups because of their isolation and because of an inability to depend on the extended clan support system that is a critical feature of social protection in Somalia. Unless the new Somali government dedicates specific resources to addressing the health care needs of minority groups, they could be left behind in the new Somalia.

South Sudan

South Sudan is home to an estimated 56 ethnic groups and almost 600 sub-groups. After the excitement of South Sudan's independence in 2011, the year 2012 was characterized by continuing conflict with its northern neighbour as well as internal ethnic divisions that regularly erupted into conflict. Health status and the ability to access care were often directly related to the political and inter-ethnic crises still

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Case study by *Chelsea Purvis*
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Ogiek in Kenya

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The plight of the Ogiek community highlights the impact of land-grabbing, displacement and discrimination on health.

The Ogiek are an indigenous group of about 20,000 people in Kenya. The Kenyan government has repeatedly and forcibly evicted the Ogiek from their ancestral land in the Mau Forest and around Mount Elgon. This has left entire communities of Ogiek homeless or without proper housing, in some cases for generations. During evictions, police have burned homes and food stores – exposing the Ogiek to hunger and homelessness – and assaulted Ogiek individuals. Injured Ogiek, fearing the government, are unable to seek medical attention from government hospitals.

Many Ogiek are completely landless and live without proper shelter and food, safe water and sanitation. Ogiek of the Serenonik area, for example, live in an informal settlement along the edge of a public road. Large families crowd into one-room shacks. The sick and elderly must sleep on the bare ground. It becomes very cold in hilly Serenonik, but the community has little clothing and few blankets. As a result, children die from diseases like pneumonia and from exposure. The community has no place even to bury its dead.

Ogiek communities have been pushed into deep poverty. They are cut off from the forest, where the Ogiek traditionally hunt and gather their food, and they are discriminated against in government employment. This leaves Ogiek with no choice but to engage in low-paid agricultural wage labour. Ogiek struggle to pay medical fees and the cost of transportation to hospitals, which may be many kilometres away.

Ogiek with disabilities or major illnesses are particularly vulnerable. Kenya has no national

health insurance, so already-impooverished families are left to bear the costs of caring for people with disabilities or major illnesses on their own. Families are forced to take out loans to pay for medical care, leaving them deep in debt. Major surgeries can cost up to 140,000 Kenyan shillings (£1,100), while the average family in Western Mau earns only 2,000 Ksh (£16 per month).

Separated from the forest, the Ogiek cannot easily access traditional medicines such as *kapukeriet*, to treat respiratory illness, and the African wild olive, to treat malaria. Poverty is so severe in some communities that Ogiek experience chronic hunger. The Kenyan government provides only occasional food relief, which is insufficient to prevent hunger.

Ogiek women and girls are also particularly vulnerable. Women and girls living in informal settlements are at risk of violence due to insecurity from overcrowding, exposure to roads and neighbouring communities, and a lack of toilet and bathing facilities.

In one community, there have been reports of rape and sexual abuse of girls by people from outside the community, in some cases leading to child pregnancy. The local government has done nothing to investigate the crimes or help the girls. When community members reported the crimes to a journalist, local officials finally visited the community – but only to publicly criticize

Below: An Ogiek family in Kenya.

Isobel Matheson/MRG.



Case study continued

the complainants and the victims, calling them troublemakers and liars.

Early marriage and transactional sex are serious problems among adolescent Ogiek girls. Evictions have broken families apart, leaving girls and young women to fend for themselves. Moreover, Ogiek girls lack educational and work opportunities. Secondary school is expensive, and Ogiek report that local governments discriminate against Ogiek in awarding financial-based scholarships. Seeking income and food, girls are thus pushed to engage in transactional sex with adult men or to marry before they turn 18. Girls who engage in transactional sex or marry early are vulnerable to high-risk pregnancies, sexually transmitted infections including HIV/AIDS and abuse.

Adolescent pregnancy is a major health issue for Ogiek girls. Pregnant girls often hide their pregnancies, preventing them from obtaining appropriate prenatal care. Sometimes communities are not aware that girls are pregnant until they are in labour, when it is too late to take girls to distant hospitals. This means that girls must deliver in unsafe conditions. Ogiek girls drop out of school when they become pregnant and the government provides little assistance to reintegrate them. This locks Ogiek families into a cycle of poverty. Mothers of all ages struggle to obtain pre- and postnatal care because of long distances to hospitals and the high cost of treatment.

The plight of the Ogiek community highlights the impact of land-grabbing, displacement and discrimination on health.

The government of Kenya should cease evicting Ogiek and provide them with secure ownership of their traditional land. The government should also end discrimination in employment and distribution of school funds. To protect women and girls, the government should ensure that girls remain in school; investigate and prosecute gender-based violence; and provide reproductive health care. ■



ongoing in the country. Moreover, access to health services for minorities and indigenous peoples in South Sudan is hampered by lack of infrastructure to facilitate travel to a clinic or hospital, poverty and the resulting inability to pay for health services, as well as discrimination.

Conflicts between South Sudan and Sudan over oil revenues continued throughout 2012. In January 2012, South Sudan shut off oil production entirely, citing the high price Sudan was demanding to use its pipeline. The government of South Sudan obtains 98 per cent of its revenue from oil production.⁴ As a result, the reduction in government funds had a direct impact on the provision of health services. South Sudan has the highest maternal mortality (2,050 deaths per 100,000 live births) and under-five mortality rates in the world. Of the 17 neglected tropical diseases recognized by the WHO, all



Above: A Murle woman in Pibor, South Sudan.
PA Images.

are present, and endemic, in South Sudan. More than half of South Sudan's 10.5 million people live more than a three-mile walk from any basic primary health facility. There are only 37 hospitals in the country. Plans for enhancing South Sudan's health sector and transferring more responsibility away from donors and to the government stalled when oil production was shut down for nine months of 2012.

Inter-ethnic conflict also has a severe impact on health status and access to services, particularly for minority groups. In Jonglei State, in the south-eastern part of the country, conflict between Lou Nuer and Murle communities continued in 2012. The year began with a massacre in Pibor town. Revenge attacks and counter-raids continued. Despite the presence of UN troops in the state, government disarmament campaigns, as well as numerous attempts at

conflict resolution through engagement with community leaders and local politicians, the cycle of violence has continued.

For those caught up in the Jonglei fighting, the nearest medical facility equipped to address the resulting serious injuries was a five-hour boat ride away. Even in the absence of conflict, minorities in Jonglei report that they are often afraid to seek health services because of discrimination – they fear that medical service providers from the dominant community will not provide effective treatment or might even harm them if they seek care. Whether justified or not, these fears have a direct impact on the health of minority groups.

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Conflict in the Nuba mountains drives famine and disease

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In 2012, one of the world's most devastating humanitarian crises was unfolding along the border between Sudan and South Sudan in the Nuba mountains. The people of Nuba include a number of different ethno-linguistic communities, as well as different religious groups, living side by side. They have been marginalized for decades by the Sudanese government in Khartoum, and the region has now become a conflict hotspot. As a result of marginalization and large-scale government land acquisitions in the region, Nuba leaders supported the Sudan Peoples' Liberation Army (SPLA) in its war against the government in Khartoum. When negotiations led to South Sudan's secession, the fate of the Nuba region was left unresolved.

In 2011, conflict erupted between militia

factions in the region and the Khartoum government. By 2012, thousands from Nuba communities, as well as other communities perceived to be anti-government, were under attack via an intensive government bombing campaign.

The conflict has created a health and humanitarian crisis. Fear of bombings has displaced thousands into mountain caves and prevented the planting of food crops. Bomb-related injuries have intensified the strain on an already limited health care system. Delivering humanitarian aid to the region has become extremely challenging – because of the active conflict as well as the refusal of the government to allow much assistance – leading to terrible conditions for those living in Nuba. Because it has not been possible to move vaccination to the region, outbreaks of measles and other preventable childhood diseases are a serious concern.

Thousands of refugees have fled to South Sudan, but conditions in the camps there were also described as desperate in 2012, with rampant disease and malnutrition. Some have likened the tactics of the Khartoum government to those used in the Darfur region, with indiscriminate attacks on civilians and use of food as a weapon of war. ■

South Sudan is also hosting hundreds of thousands of refugees and internally displaced people as a result of continuing conflict with Sudan and within South Sudan. Refugee flows throughout 2012 have led to dire conditions in the remote camps on the border between South Sudan and Sudan, with rampant disease and malnutrition leading to thousands of preventable deaths. Minority communities and indigenous peoples, who often make up a substantial proportion of refugee flows and who are often found in the most remote areas, are particularly negatively affected by the dire state of health services.

Uganda

The health sector in Uganda faced multiple challenges in 2012. At the end of the year,

reports ranked Uganda's health sector as the most corrupt in the East African region, citing extensive problems with bribery and health care worker absenteeism as major contributors. Uganda also saw worrying reversals in its generally successful HIV/AIDS prevention programme, as well as outbreaks of several rare diseases, including nodding disease, Ebola virus and Marburg haemorrhagic fever. The Ugandan parliament threatened to block the entire national budget unless there was an increase in funding for the health sector, which the WHO had described as having a severe health worker shortage. For minorities and indigenous peoples, who generally have less access to health services than the general

Right: Batwa woman and child, Uganda.
Michael Pitt.



population as a result of marginalization and poverty, these nationwide health sector challenges can have an disproportionate impact.

In a shadow report to the UN Universal Periodic Review process for Uganda, a coalition of minority and indigenous rights groups highlighted concerns about health status and access to services. Major challenges included (1) loss of access to traditional medicinal herbs because of environmental degradation and land loss, as well as reduced transmission of knowledge on traditional methods of healing; (2) failures of the Ugandan health system to account for minority and indigenous peoples' needs in their policy and planning processes; and (3) lack of culturally appropriate health service provision, especially in the area of reproductive health. The coalition reported statistics that highlight disparities in health status:

'[A]mong the Batwa women of Kisoro, there are two still births out of every dozen live births (with an infant mortality rate of 17 per cent) and only five out of 10 children reach their first birthday. Further, out of those five children, few reach their fifteenth birthday. These figures are far worse than the national averages, i.e. an 11 per cent infant mortality rate, and an 18 per cent chance of dying before the first birthday.'

HIV/AIDS also often has a disproportionate impact on minorities and indigenous peoples, so increasing rates in 2012 are a concern. For many years there were substantial drops in HIV infection rates in Uganda, attributed to a high-profile public-awareness campaign, testing programmes, treatment provision, and substantial donor support. From 1992 to 2000, HIV prevalence rates dropped from 18.5 per cent to 5 per cent,⁵ but data released in 2012 indicated that this trend is reversing, with a prevalence rate of 7.3 per cent. Rates are increasing across the population, in urban and rural areas, and in particular among adult married couples.

Loss of access to and control over land and natural resources are also related to health status for minorities in Uganda. In mid-2012, Uganda announced that oil reserves initially discovered in 2010 were even larger than reported, amounting to 3.5 billion barrels. The Buliisa

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Batwa – sexual violence and lack of health care spreads HIV/AIDS

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Displacement and loss of access to ancestral territory has had devastating effects on indigenous peoples, including on their health status. Arguably, those most severely affected have been the Batwa communities of East and Central Africa. With recent news about increases in HIV infection rates in Uganda, MRG interviewed Faith Tushabe, Executive Director of African International Christian Ministry, an NGO that works closely with Batwa communities on the impact of HIV/AIDS and other health concerns for Batwa in Uganda.

MRG: What are the major health issues for Batwa communities you work with?

FT: For Batwa, health concerns are directly linked to their displacement from the forest, to social discrimination and to their extreme poverty. Traditionally, Batwa depended on forest products to provide medicines and food products for the community. In addition, their isolation inside the forest reduced their exposure to many illnesses. Today, as a result of their eviction, they have lost access to many traditional forest products that contributed to their health. They also have difficulty accessing health services provided by the Ugandan

district, inhabited by the Bagungu indigenous fishing community, has been a major centre for oil exploration, which has led to community concerns about possible environmental damage

government. For example, in order to access antiretroviral treatment and other care and support services for men and women living with HIV, Batwa have to walk approximately five kilometres.

Batwa resettlement never provided sufficient land to ensure food security, so, particularly for those living with HIV/AIDS, the inability to provide sufficient food has a negative impact on their health status. Discrimination also hinders Batwas' ability to access health services, as many health workers perceive them negatively.

Shelter and sanitation is another major health concern. Poverty and lack of land makes it extremely difficult for Batwa families to build sufficient shelter with adequate sanitation. As a result, babies and young children are at high risk of pneumonia during cold seasons and hygiene-related diseases spread easily through the community.

MRG: What is the prevalence of HIV/AIDS in Batwa communities?

FT: The high level of stigma and discrimination has affected access to HIV/AIDS services, reducing the number of Batwa men and women who go for counselling, testing and other care services. This has affected the data analysis on the prevalence rates, so it is difficult to know the actual rate of HIV in the community. Despite the difficulty in gathering data, it is clear that HIV is having negative effects in the community, including decreases in productivity because of illness and an increase in orphans and vulnerable children because of the death of parents as a result of HIV. Couples' counselling and testing have also been hard to conduct, which has led to high risk of HIV infection and other sexually transmitted infections like syphilis. There are very limited HIV/AIDS services, including basic education information, as well as care and support, in the Batwa resident centres.

MRG: Does HIV/AIDS affect Batwa men and women differently? How?

FT: Batwa women are affected differently from men for a number of reasons. Some Batwa women have been subjected to rape and also are coerced into sexual relationships in exchange for basic goods, which because of poverty they cannot afford. Sexual assaults and sex for goods/money is generally as a result of interactions with other neighbouring ethnic communities. Other ethnic communities have discriminatory perceptions about Batwa women, believing that having sex with a Mutwa will cure diseases such as backache or HIV. Also, Batwa women often are believed to be HIV-free, which paradoxically has led to the spread of HIV.

MRG: What health services in general are available in areas where Batwa are currently living?

FT: Batwa reside in eight centres in the four sub-counties of Muko, Ikumba, Bufundi and Butanda in the Kabale District. Primary care, reproductive health, HIV/AIDS care, water and sanitation services are generally available from the regional hospital and other local health centres. However, fees for service are a major barrier for Batwa accessing care. Also Batwa sometimes have negative perceptions of the health care system, as they often experience discrimination, which reduces the likelihood that they will seek out health services. ■

and the spillage of toxic material in the area, which could have negative impacts on health status. The oil company operating in the region has funded the construction of a local hospital

(yet to open), sponsored male circumcision campaigns to reduce the risk of HIV infection, and has also trained peer health educators in local villages.

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Case study
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Obstetric fistula – a preventable but deadly condition for mothers in sub-Saharan Africa

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Girls who marry young or suffer genital mutilation are at highest risk from obstetric fistula, a hole in the birth canal caused by prolonged or obstructed pregnancy. The condition is easy to treat – the difficulty is getting women the medical care they need.

Obstetric fistula generally occurs as a complication of pregnancy during which labour becomes obstructed – it is often a result of women labouring for many hours or days without access to medical care. Obstructed labour leads to the development of internal tears and leaves women with chronic incontinence. In most cases the baby is stillborn. Left untreated, fistula can lead to chronic medical problems.

While fistula is rare in parts of the globe where emergency obstetric care is available, in sub-Saharan Africa fistula remains a serious health problem. The East, Central and Southern African Health Community (ECSA-HC) estimates that there are approximately 3,000 new fistula cases every year in both Kenya and Tanzania, and that an estimated 250,000 women in Ethiopia are living with fistula.

MRG talked with Jared Momanyi, the project manager at Gynocare Fistula Centre in Eldoret, Kenya, to learn more about the impact of fistula and how the problem can be addressed.

MRG: Why is fistula an issue for minority and indigenous communities?

JM: Female genital mutilation (FGM) and early marriage are major risk factors for fistula because they increase the risk of obstructed delivery.

Girls who become pregnant before age 19 are at higher risk for fistula because their bodies are not yet fully developed for childbirth. We see a higher rate of these practices in minority and marginalized communities in Kenya and across East Africa. For example, many of our cases come from Pokot, where rates of FGM and early marriage are high. We have begun seeing an increase in cases from Samburu and Maasai communities recently, as those groups have begun to learn about our services. Poverty also is a risk factor, as poverty can lead to girls being married at an earlier age and then have higher risk for fistula.

MRG: How does fistula affect women in their families and communities?

JM: The stigma associated with fistula is terrible. Because the condition leads to a constant smell of urine, many women are pushed away from their families and communities. For example, just the transport for a woman to come to the hospital can be a difficult experience. Here in Kenya we use *matatus* (minibuses that seat 14 people in close quarters) and people may refuse to travel with a woman who has fistula because of the smell. How can you get to the hospital if no one will bring you? We have women here who have been dealing with the condition for many years. The victims are so poor and have limited communication with the world outside their community so they may remain with fistula for more than 50 years in some cases. The treatment women have experienced often is so bad that after the surgery some of them do not want to go home. We continue to try to find ways to work on community reintegration for survivors.

MRG: What services does Gynocare's programme provide for women and girls who have fistula?

JM: Gynocare clinic was started by Dr Hillary Mabeya in 2010. Since then we have conducted more than 850 fistula repairs, but we have 300 women on our waiting list. We provide women and girls with surgical repair, post-operative recovery and counselling. The psychosocial impacts on women are very severe and, for many, coming to the clinic is very frightening, so our counsellors provide a critical service

to help women feel comfortable. While women are in recovery they stay here with us and we provide their food and housing. The services are free of charge and we receive donor funding to support our work, in particular from Direct Relief International and One By One Fistula Foundation. We have also started a programme in which survivors become community educators. After they have successfully recovered, interested women are trained to spread the word about fistula and to help identify women who are in need of our services. We also have some cases of young girls who come to our clinic. If we find that they might be in danger if they return to their community or if they wish to stay in school, we try to support them financially to do so.

We actually have been receiving patients from other East African countries, including Uganda, Tanzania and even South Sudan. Although there are fistula services in those countries, often it is easier for women living in border areas to reach our services. ■

Southern Africa

Inga Thiemann

Enjoyment of the right to health is not a matter of course in Southern Africa. High numbers of HIV, tuberculosis and malaria cases are a problem across the region, while health care facilities are often hard to reach. Public health care facilities are regularly under-stocked and under-staffed, while private health care is usually unattainable for the majority of the population, including most indigenous and minority groups.

Indigenous and minority communities living in remote areas often have no access to health care facilities and life-saving medicine, and public health information is not available in their own languages. Equally, they are often the last ones to be reached by educational campaigns regarding HIV, tuberculosis and malaria prevention, putting their lives at an even higher risk compared to the general population. This is further aggravated by the double marginalization HIV-positive members of minority and indigenous groups face.

HIV/AIDS is a major concern for San communities in Botswana. While the government of Botswana provides free antiretroviral medication, treatment is not always as accessible for San in remote areas. San leaders from central Botswana say that many San do not understand the disease fully and therefore do not access treatment until it is too late. For them, as well as for other indigenous communities in remote areas, early intervention needs to be promoted.

Namibia

Minority and indigenous rights remain difficult issues in Namibia due to the legacy of apartheid. Despite some government efforts to improve their situation, indigenous peoples still have not benefited from independence as much as other groups. In a visit to the country in October 2012, James Anaya, the UN Special Rapporteur on the rights of indigenous peoples, expressed

concern about the lack of a coherent government policy that assigns a positive value to the distinct identities and practices of indigenous people and promotes their cultural survival.

In January 2012, 36 traditional Himba leaders, one of the country's most marginalized groups, issued a statement to the UN describing their grievances. They claimed the government has refused to recognize 33 of them as traditional leaders, despite winning their case in the high court in 2001. Himba leaders also challenged the 2002 Communal Land Reform Act, which allows others to buy land traditionally owned by Himba. The leaders called for the government to remove mining companies from Himba territories or involve the Himba in the decision-making about mining permits and mining revenue.

Himba children do not have access to education and funding has decreased for mobile schools for their children. Himbas' semi-nomadic lifestyle means their children are unable to attend mainstream schools. Both Himba and San children face discrimination at school; they are not allowed to wear traditional clothes and are not taught in their mother tongue, which affects their quality of education and knowledge about health issues. Himba leaders also demanded better health care and more hospitals in their areas. Access to health facilities remains one of the main obstacles to medical treatment for all nomadic and pastoral minorities in Namibia.

Indigenous groups are also more vulnerable to HIV infection, because of their comparatively low access to sexual and reproductive health services and information. Namibia has an adult HIV prevalence rate of 13.4 per cent,⁶ but indigenous groups do not always know about the risks. A 2009 study revealed that 80 per cent of women in a San community in Tsumkwe did not know if HIV/AIDS was a problem in their community and 85 per cent responded 'do not know' when asked about their risk of infection. There are no public health campaigns in San languages.

Maternal mortality rates have doubled since the early 1990s, mainly due to HIV. This is despite an increased number of women with access to skilled birth attendants (81 per cent) and receiving antenatal care (70 per cent), according to the latest UN Development Programme (UNDP) Millennium Development

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Innovative mobile tuberculosis treatment reaches Namibia's nomadic San community

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San are the only ethnic group in Namibia whose health and economic status have declined since independence. San life expectancy is 22 per cent below the national average. Namibia has one of the highest tuberculosis rates in the world. In parts of Tsumkwe where San live, rates of more than 1,500 tuberculosis cases per 100,000 people



were recorded in 2004, which is almost 50 per cent higher than the national prevalence rate for the same period.⁷

The San region of Tsumkwe has high levels of multi-drug-resistant tuberculosis because they live in remote places and often move their homes and go on long hunting expeditions, which means they do not finish courses of medicine. Unwittingly, they therefore contribute to one of the chief causes of drug-resistant illnesses. However, the San, with the help of two NGOs, devised a health programme that takes into account their lifestyle. Family members are trained to administer drugs and a community-based education programme taught San about tuberculosis, required drugs, how to read and record treatment cards and how to collect medical samples. As a result, recent data indicates a decrease in multi-drug-resistant tuberculosis cases in Tsumkwe.⁸ ■

Below: San children playing a traditional game, Namibia. Paul Weinberg/Panos.



Goals (MDG) report. However, indigenous communities in remote locations are less likely to benefit from antenatal care and skilled birth attendants, and while their exact maternal and infant mortality rates are not fully documented, experts believe them to be extremely high.

South Africa

The 'Rainbow Nation' continues to be affected by its colonial and apartheid legacy. Land rights and distribution of wealth remain contested issues in South Africa. Per capita personal income among white South Africans is nearly eight times higher than that of the country's black citizens, according to the South African Institute of Race Relations. The redistribution of farmland from white owners to black citizens has progressed slowly, hindered by government mismanagement. Economic competition between small-scale black-owned farms and large-scale factory farms owned by whites exacerbates the problem by leading to economic failure and buy-backs by white farmers.

Frustrations about the process have also led to an outbreak of violent farm invasions, leading to casualties among white South Africans in 2012. The outbreak in violence is linked to calls by Julius Malema, the former president of the African National Congress (ANC) Youth League, for whites to give up their land without compensation or face violence by angry black youths 'flooding their farms'. Malema was charged with hate speech in 2010 and 2011 and was expelled from the ANC in April 2012. One of the incidents of hate speech included singing the song 'Shoot the Boer' (a South African term simultaneously used for white farmers and descendants of Dutch-speaking white settlers).

In January 2012, President Jacob Zuma also sang 'Shoot the Boer' at the ANC centenary celebration. He claimed that this was not intended as hate speech, but to commemorate the struggle against apartheid. However, his actions may contribute to an increase in ethnic tension.

Land rights continue to be an issue for the Khoisan indigenous community, who feel disadvantaged by the provisions in the 2011 land reform green paper. The reform does not take into account dispossession of land before 1913, which, according to the Khoisan group Sapco, excludes most Khoisan claims. However, Khoisan

can apply for land under the government's redistribution programme, according to academics. Nonetheless, Sapco representatives, as well as some Dutch-speaking Afrikaner groups, argue that the current land reform policy will benefit the black majority but not minorities or indigenous communities.

South Africa took a big step towards improving general health care in the country in 2012 by introducing the first stage of a universal health care plan. The national health insurance, first introduced in 10 selected districts, is intended eventually to provide essential health care to all citizens and legal residents. This will greatly benefit the black majority and minority groups that suffer from a rudimentary public health care system, which provides services for 80 per cent of the population, and a lack of doctors in public health care. A rich white minority tends to benefit from private health care providers.

The introduction of universal health care could also benefit the highly marginalized San communities. New health care facilities in remote San regions will facilitate their access to health care services and medicine.

The South African government has also taken steps to formalize the role of traditional healers. In February the government inaugurated the Council for Traditional Health Practitioners to regulate the quality of services delivered by diviners, healers, traditional birth attendants and herbalists, and to protect the public from bogus practitioners. Traditional healers play an important role in South African health care, since they are often more likely to be contacted than western doctors, especially by the Zulu and Xhosa communities.

The 42 deaths and hundreds of injuries of Xhosa boys from botched circumcisions in the first six months of 2012 highlighted the need for stronger regulations for traditional healers. Most deaths and injuries in the ritual have occurred in the Mpondoland region of Eastern Cape. The Eastern Cape House of Traditional Leaders insists it is taking the problem seriously and running a campaign for safety at initiation schools.

South Africa has the highest number of people living with HIV/AIDS in the world, but there are large differences between communities.⁹ The mainly Zulu minority region KwaZulu-Natal has the highest HIV prevalence, with 15.8 per cent, followed by

the Swati- and Zulu-speaking Mpumalanga region, with 15.4 per cent (compared to the national average of 10.9 per cent and 3.8 per cent in the Western Cape). Women are significantly more likely to be HIV-positive. The overall HIV prevalence in South Africa is slowly decreasing, but at the same time the HIV prevalence among young pregnant women has increased from 22.8 per cent in 1994 to 29.3 per cent in 2010. If current trends continue, South Africa is unlikely to achieve all its MDGs on HIV.

The highest HIV prevalence rates among women attending antenatal clinics are in KwaZulu-Natal (39.5 per cent) and in Mpumalanga region (35.1 per cent), according to a 2010 study by the South African Department of Health.

In some Zulu communities misinformation about HIV puts female babies and young girls at a particularly high risk. The so-called 'virgin cleansing myth', according to which an HIV-positive person can be healed through intercourse with a virgin, is held responsible for higher numbers of sexual assaults against female minors.

Tuberculosis remains the main cause of death in South Africa. It is linked to the high prevalence of HIV. South Africa accounts for 28 per cent of the world's people living with both HIV and tuberculosis. People whose immune systems have been weakened by HIV are much more likely to be infected with tuberculosis.

Zimbabwe

Political reform in Zimbabwe has been slow and insufficient, despite a new draft constitution and the implementation of the Global Political Agreement (GPA), which was signed in 2008. There has been no end to political violence and discrimination, including against the white minority and gay rights activists. The Zimbabwean government was also accused of reintroducing youth militias to create fear among political opponents prior to the 2013 elections.

In February 2012, the governor of Mazvingo province suspended 29 NGOs providing services ranging from food aid to assisting people with disabilities, for failing to register with his office. While the governor lacked the legal authority to do this, his action caused fears of a crackdown on NGOs similar to the one that preceded elections in 2008.

Health

Meanwhile, a combination of unpredictable rainfall and limited access to seeds and fertilizers caused the number of people in need of food aid to rise by 60 per cent, making more people vulnerable to illness due to malnutrition.

Zimbabwe is expected to fall short of most of its health-related MDGs. The number of maternal deaths has more than doubled since 1990, and the under-five mortality rate increased from 79 per 1,000 in 1990 to 94 per 1,000 in 2009.

However, Zimbabwe has reduced its HIV/AIDS prevalence rate from 23.7 per cent in 2001 to 14.3 per cent in 2010 and is likely to reach this MDG target. While the government has run significant awareness campaigns, including an event in June 2012 when 44 members of the Zimbabwean parliament were circumcised, gender inequality still hinders the effectiveness of HIV campaigns.

Globally, the country ranks 17 out of 22 high-burden tuberculosis countries. The incident rate rose from 97 per 100,000 people in 2000 to 782 per 100,000 in 2007. According to government statistics, more people from Matabeleland are dying from tuberculosis than in any other area of Zimbabwe. Matabeleland is the homeland of the Ndebele minority and has been particularly affected by drought. Up to 18 per cent of patients in Matabeleland North province and 14 per cent in Matabeleland South province die while on tuberculosis treatment.

West and Central Africa

Paige Jennings

The Sahel region, including parts of Burkina Faso, Cameroon, Chad, Mali, Mauritania, Niger, Nigeria, Senegal and Sudan, suffered the worst drought in decades, followed in

places by flooding. This led to poor harvests, food shortages and rising food costs amongst chronically vulnerable populations.

The impact was compounded in some areas by conflict and displacement. By year's end 18.7 million people faced food insecurity in the Sahel, with over 1 million children at risk of dying from acute malnutrition.

The year 2012 also saw the most serious outbreak of cholera in years in Guinea, Liberia and Sierra Leone, as well as along the Congo River in the Republic of Congo, the Democratic Republic of Congo (DRC) and western Niger.

Ten years on from the end of a brutal civil war, fuelled in part by regional interests seeking to control the country's lucrative diamond fields by exploiting domestic tensions, former Liberian president Charles Taylor was convicted by the Special Court for Sierra Leone of war crimes and crimes against humanity.

To aid recovery, in 2010 Sierra Leone opened a programme to provide free health care to pregnant women, breastfeeding mothers and children under five. Since then, use of health services has reportedly increased by 60 per cent, with, for example, five times as many children receiving the recommended malaria treatment as in 2008. In other positive developments, in November Sierra Leone held peaceful presidential, legislative and local elections.

Despite some electoral violence, Senegal continued its process of democratic transition when the incumbent conceded defeat in March polls and handed power peacefully to the opposition. In August the UN Committee on the Elimination of Racial Discrimination (CERD) expressed concern at renewed violence between the army and separatists in the Casamance region, which is populated largely by the minority Diola ethnic group.

In December Senegal and the African Union (AU) set up a special tribunal to try Chad's former dictator Hissène Habré for human rights violations committed during his eight years in power, ending in 1990. Victims included his political opponents and members of ethnic groups he believed opposed him.

The year 2012 saw an upsurge in attacks by the armed Islamist group Boko Haram in Nigeria (see country section below). Security forces,

Christians and Muslims suspected of opposing the group appeared to be the primary targets; violence centered on the predominantly Muslim north, though attacks occurred elsewhere as well. For their part, security forces were accused of numerous human rights violations, including during raids on communities that had previously been attacked by Boko Haram.

In Mali, a Tuareg-led uprising followed by a coup ended a 20-year stretch of democratic transition (see below), while in Guinea Bissau, the first round of presidential elections was followed by a military coup in April.

In March, the Central African Republic (CAR), DRC, South Sudan and Uganda announced a 5,000-strong UN- and AU-backed joint military task force to combat the notorious Lord's Resistance Army (LRA).

By year's end the LRA had carried out at least 180 attacks in the CAR and DRC, including against minority ethnic groups, forcing some 443,000 people to flee their homes.

Following the 2011 adoption by the Republic of Congo of Africa's first law on indigenous rights, CERD raised concerns about reports of discrimination against indigenous peoples there.

For its part, the UN Committee for the Elimination of Discrimination against Women (CEDAW) expressed concern about the vulnerability of the Republic of Congo's indigenous women and girls to sexual violence, and about ongoing reports of discrimination against them by health workers.

The World Heritage Committee, the body considering the nomination of the Tri-National de la Sangha protected area, including parts of Cameroon, CAR and the Republic of Congo, as a UNESCO World Heritage Site, raised concerns in 2011 about lack of consultation with local indigenous populations. Some consultations were held in early 2012, but civil society groups reported that the process was flawed. The application was resubmitted in 2012 by the concerned authorities, and the area was inscribed or declared a World Heritage Site by the Committee at its July session.

The Sahel drought sharpened endemic hunger and malnutrition, leading the government to declare a state of emergency in the north.

The UN Special Rapporteur on the right to

Right: Mbororo children in Cameroon. *Emma Eastwood/MRG.*

food, Olivier de Schutter, visiting Cameroon in July, expressed grave concern at food insecurity there. Cameroon's progress against Millennium Development Goals (MDGs) health indicators remained weak; for example, its infant mortality rate declined by only 1.2 per cent between 1990 and 2010. Cameroon, one of UNAIDS' (UN and AIDS) 22 priority countries, achieved a moderate decline in new HIV infections among children between 2009 and 2011 (MDG 6).

In January, the UN Committee on Economic, Social and Cultural Rights (UNESCR) urged Cameroon to protect indigenous peoples' rights to their ancestral lands and any natural resources there.

For his part, the Special Rapporteur noted that the enjoyment of the right to adequate food was particularly threatened among indigenous peoples. He called for the government to consider a stricter tax regime for the (primarily foreign-owned) companies that draw on Cameroon's resources and to ensure a greater voice for indigenous groups in allocating the proceeds.

Forest-dwelling groups

The Special Rapporteur expressed fears that large-scale agroforestry and agriculture on their lands would deepen the marginalization of forest-dwellers.

The culture and livelihoods of the indigenous Ba'Gyeli people were reportedly threatened by international palm oil companies' plans, developed without consultation, to clear their forest for cultivation.

A July NGO report found that allocation of traditional lands to agriculture, agroforestry or logging put the culture and livelihood of the formerly nomadic Ba'Aka similarly at risk.

It pointed to high child mortality and low life expectancy rates among the Ba'Aka, who had poor access to health care due to discrimination, cost and lack of identity documents; those who managed to maintain access to the forest were said to have a higher standard of health in some respects due to their skills in traditional medicine.

Contrary to international standards, the 1994 Forest Code does not recognize indigenous



rights to traditional lands and resources. In 2012 the law was under revision; in its Concluding Observations in January, the UNESCR urged Cameroon to speed up the reform process and to guarantee indigenous rights. However, civil society groups raised doubts about the content of draft reform proposals, the tight timetable of the review process and its failure to fully respect indigenous groups' right to consultation.

Nomadic pastoralist groups

In November, the Mbororo Social and Cultural Development Association (MBOSCUA) representing the minority Mbororo cattle-herding community from different provinces of Cameroon, and the International Land Coalition (ILC) Africa, a global coalition of organizations focusing on land access issues for rural people, organized a conference on 'Securing the land rights of indigenous people and rural communities', with 95 participants from 22 countries. The resulting Yaoundé Declaration

addressed challenges such as increasing landlessness due to privatization, the effects of population growth and climate change, and the impact of creating national parks and protected areas on indigenous peoples.

At a workshop in November on voter sensitization and registration in the run-up to 2013 elections, Mbororo activists called for the adoption of a Pastoral Code governing farmer–grazer relations. Other key issues raised included access to the identification documents needed for voting, and the interconnection between education and meaningful political participation – including for girls.

Côte d'Ivoire

Despite 2011's return to constitutional order, Côte d'Ivoire remained unstable in the face of a wave of attacks generally attributed to supporters of former President Laurent Gbagbo. While in power, and in particular during the 2010 electoral campaign, Gbagbo's use of xenophobic

language and manipulation of ethnicity and citizenship exacerbated tensions between the south and the largely Muslim north.

Following his refusal to concede defeat at the polls, his supporters were accused of widespread human rights violations against those of his opponent Alassane Ouattara. By the time of Gbagbo's departure in 2011, serious violations based on perceived ethnicity or political affiliation had been attributed to both sides.

In 2012 security was unstable, with internal as well as cross-border attacks from Liberia and Ghana. In June, seven UN peacekeepers, patrolling in response to reports of an attack on civilians the night before, were killed, reportedly by pro-Gbagbo militias, in an ambush outside of the town of Tai.

In July soldiers, pro-Ouattara militias and ethnic Malinké civilians attacked the Nahibly camp for internally displaced people, leaving at least 11 dead and several score injured and forcing thousands more to flee. Many of the camp's inhabitants were ethnic Guérés and had supported Gbagbo; it was said to have been attacked in retaliation for deaths during an armed robbery in nearby Duékoué that the attackers believed had been carried out by camp residents.

In October staff of the International Federation for Human Rights and two of its member organizations in Côte d'Ivoire reported being present at the discovery of a mass grave that they believed to be of a further six victims of the July attack on the camp.

From August, police and security forces were increasingly targeted by Gbagbo supporters.

In response they cracked down on Gbagbo supporters and those from his ethnic group, reportedly committing violations such as arbitrary arrest, ill-treatment and torture.

At year's end, Gbagbo and his wife Simone faced charges before the International Criminal Court (ICC), and scores of their supporters had been brought before domestic courts on charges of committing abuses against Ouattara loyalists during the conflict. No judicial proceedings had been instigated against Ouattara supporters, however, despite the fact that the report of the National Commission of Inquiry into the electoral violence referred to cases of serious human rights abuses by both sides. Some observers expressed

concern that the ICC's decision to 'sequence' its enquiry into events in Côte d'Ivoire, investigating Gbagbo and his camp first rather than addressing abuses by both sides simultaneously, was being used domestically to justify the pursuit of one-sided justice in the national courts.

Health

The drought in neighbouring Sahel countries increased hardship by raising food prices; ongoing insecurity further disrupted livelihoods. Ouattara had set up nationwide free health care in 2011 to aid recovery from the earlier violence; in March the programme was scaled back to pregnant women, children under age five and malaria patients.

As one of UNAIDS' 22 priority countries, Côte d'Ivoire achieved a moderate decline in new HIV infections among children between 2009 and 2011 (MDG 6). It made some progress in child and maternal mortality, though reportedly not enough to reach the 2015 MDGs.

At its 52nd session, held in Côte d'Ivoire in October, the African Commission on Human and Peoples' Rights (ACHPR) reviewed Côte d'Ivoire's periodic country report. In its Concluding Observations, it recognized positive measures such as the establishment of a ministry for combating HIV, but expressed concern at lack of access to basic health services, particularly for women and girls.

The Concluding Observations also expressed concern at the failure to implement a 1998 law banning female genital mutilation (FGM) and sexual harassment. In the first application of that law, in July, nine women in the northern town of Katiola were convicted of carrying out FGM.

According to government and UN statistics, the practice is most prevalent in the north and west of the country, its frequency varying across religious and ethnic groups; it is also practised by immigrants from neighbouring countries with high FGM rates. According to UNICEF, nearly 88 per cent of women are affected in northern Côte d'Ivoire, and 73 per cent are affected in the west.

Mali

The year 2012 was one of unprecedented crisis in Mali, which has a tradition of moderate Islam

and a 20-year democratic history. On top of the Sahel food emergency, the country was wracked by fall-out from an armed rebellion. Northern Mali is home to the Tuareg and Maure (Moor) ethnic groups, both traditionally nomadic.

The Tuareg had been in low-level conflict with colonial and post-colonial authorities for decades. Tuareg separatists protesting at marginalization, lack of development and neglect of the north, including during times of devastating drought in their communities, had carried out repeated rebellions in the hope of establishing a separate Tuareg state, Azawad.

In addition, in recent years the weak state presence had allowed armed Islamist groups and organized crime to operate and gain significant influence in the north.

The January rebellion, led by Tuareg combatants recently returned from Libya after the fall of Muammar Gaddafi in late 2011, spread through the northern Sahara region. The secular, separatist Tuareg group National Movement for the Liberation of Azawad (MNLA) acted alongside Islamist groups, which also included some Tuaregs among their combatants.

The ensuing violence led to the internal displacement of roughly 204,000 people, while more than 200,000 fled into neighbouring countries. The rebels were accused of violating humanitarian law by executing captured soldiers, and of widespread abuses against civilians, including use of child soldiers and widespread, at times ethnically oriented, rape.

For its part, Mali's army was accused of indiscriminate bombing, of targeting Tuareg civilians in reprisal attacks, and of failing to protect Tuaregs and other minorities, including Arabs and Mauritians living in the capital, from revenge attacks, including by self-defence militias of other ethnic groups.

In March, army officers, frustrated by lack of government support for their fight against the rebels, staged a coup. The rebels took advantage of the upheaval to further expand their area of control, declaring an independent state of Azawad on 6 April.

However, the MNLA was driven out by the Islamist groups, including Ansar Dine and al-Qaeda in the Islamic Maghreb (AQIM). These groups destroyed very important cultural

and religious sites, including mausoleums and shrines, and committed abuses while carrying out punishments under a strict interpretation of Sharia law.

In July Mali's Minister of Justice asked the ICC to investigate crimes committed since the beginning of the January uprising. In December the UN Security Council authorized deployment of an African-led force to support Mali's army in regaining control of the north.

Analysts raised concerns that military intervention could trigger further ethnic conflict, particularly in the form of acts of collective punishment against Tuaregs.

Health

The armed conflict added to the burdens of a population already confronting food insecurity. Conflict interrupted basic services and destroyed health infrastructure, weakening responses to outbreaks of cholera and malaria.

Reports indicated that the strict imposition of Sharia law further impeded health services, with armed men at times disrupting services to verify that female patients and staff were covered, or banning radio-based health campaigns on religious grounds. As the year progressed, aid workers reported that child malnutrition in Mali was reaching emergency levels. In January 2013 an estimated 585,000 people were suffering from food insecurity, with a further 1.2 million at risk, out of a total population of 1.8 million in northern Mali.

Nigeria

Nigeria more than doubled its per capita income between 1990 and 2010; but progress towards the MDGs has been inconsistent and hampered by sharp social inequalities.

While the country has achieved significant declines in HIV infections, and in 2010 reported good potential for meeting MDG 6 on combating infectious diseases, child and maternal health indicators continued to reflect inequalities between the poor, predominantly Muslim north and the oil-rich south.

In a particularly worrying development, in northern Zamfara state, labour-intensive artisanal gold mining has left widespread lead poisoning, especially among children, killing more than 400



of them since 2010. Around 2,500 others have received treatment, but thousands more have not. This is because environmental remediation, or decontamination, has not been undertaken, with the result that the children's exposure continues and any therapy would be ineffective.

In December an Economic Community of West African States (ECOWAS) court ordered the Nigerian federal government to enforce regulations on six oil companies responsible for oil spills, ensuring that they carry out adequate clean-up, fully compensate affected residents and take steps to avoid future pollution.

In 2011 the United Nations Environment Programme (UNEP) had published a

groundbreaking report on oil pollution in the Ogoniland region of the Niger Delta, home to the minority Ogoni people. The report found that, given that oil exploitation began in the late 1950s in the area, most residents had lived with chronic oil pollution throughout their lives, with grave impact on the traditional livelihoods of farming and fishing. It called for emergency action in response to high levels of contaminants, including benzene, a known carcinogen, in communities' drinking water, and detailed the impact of oil pollution on soil, groundwater, surface water and vegetation.

In 2012 northern Nigeria suffered the effects of the Sahel drought and, in some areas, of internal



Left: Members of Church of Christ in Nigeria are checked by a security man for guns before entering the church building in Jos. In recent years attacks have become more frequent between Christian and Muslim communities in the city. *George Osodi/Panos.*

is a sin' in the Hausa language) increased its violence in the largely Muslim north, with additional attacks elsewhere in the country. The group is primarily targeting members of the Christian community, although it has carried out bomb attacks across the country. Security forces and Muslims suspected of opposing the group appeared to be other primary targets. Security forces were also accused of numerous human rights violations, including during raids on communities that had been attacked by Boko Haram.

More than 250 people were killed by Boko Haram in January alone, 185 of them in one day of attacks on security force installations the northern city of Kano. The group appeared to be widening its range of targets, with attacks on churches, unoccupied schools and media outlets.

Mourners at funerals of some victims were attacked, prompting further inter-ethnic retaliatory violence. On 31 December 2011 President Goodluck Jonathan declared a six-month state of emergency in the affected region. Boko Haram responded with a three-day ultimatum to southern Nigerians, most of whom are Christian, to leave the North.

In the following six months, Boko Haram reportedly carried out more attacks and killed more people than during all of 2010 and 2011 together. The security forces, granted emergency powers in April, were accused of extra-judicial killings, torture and arbitrary detention against suspected militants and members of the public at large during raids in communities where attacks have occurred.

The NGO Human Rights Watch (HRW) reported in October that abuses by Boko Haram, could constitute crimes against humanity, while at the same time pointing out that the state security forces were implicated in very serious human rights violations, including extra-judicial killings, which also need to be investigated and prosecuted.

armed conflict. These factors have disrupted livelihoods, increasing residents' vulnerability to hunger and disease, including polio. Nigeria is one of only three countries in the world where polio is endemic, and the only one in Africa.

For a polio immunization campaign to be effective, it must be universal; however in the north in particular, the vaccination drive is reportedly hampered by mistrust of the initiative among the population and disrupted by insecurity caused by the armed Islamist group Boko Haram.

Boko Haram

In 2012 Boko Haram ('western education

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Case study
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Mauritania – why do Haratine women still live in slavery?

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The government must step up efforts to eradicate all forms of slavery and provide health care for its most vulnerable citizens.

Though facing serious obstacles Mauritania, 155th of 187 countries on the UN Development Programme's (UNDP's) Human Development Index, has been taking steps towards meeting the MDGs. In 2010 it was reported to be very close to halving extreme poverty, and had made slight progress against infant mortality, reducing it by 6.3 per cent between 1990 and 2010.

International analysts drew particular attention to Mauritania's progress in the area of women's participation in politics, the greatest on the African continent in 2010 following a July 2006 law that mandated a minimum of 20 per cent women's representation in municipal and legislative bodies. In 1992 there were no women parliamentarians, for example, while in 2007 they occupied 18 per cent of posts. In municipal elections in 2007, nearly 30 per cent of seats were won by women.

While its efforts to meet internationally agreed indicators have been recognized, Mauritania continues to confront a particular problem remaining from its past: slavery and its scars.

The dominant ethnic group in Mauritania is the White Maures, or Berber-Arabs. Historically they raided, captured and enslaved members of sedentary black ethnic groups, who are known today as the 'Haratines'. The term 'Haratine' is used today to refer to slaves and persons of slave descent.

The Haratines make up between 30 and 40

per cent of Mauritania's population. They are reported to be the most marginalized of the country's ethnicities; malnutrition, poverty and illiteracy are reportedly higher among them than among other groups. However, as health information is not disaggregated by ethnicity in Mauritania, the disparity is not easily quantifiable.

Boubacar Ould Massaoud, president of Mauritanian NGO SOS Esclaves, reported that roughly 80 per cent of Haratines are believed to live in poverty, and that Haratines make up the majority of the country's poor.

Despite a 2007 law criminalizing slavery, 10–20 per cent of Mauritania's population is estimated to live in slavery today; the vast majority of them



Below right: A Haratine woman in Mauritania.
Shobha Das/MRG.

are thought to be Haratines.

The March 2013 annual report of Mauritania's National Human Rights Commission (CNDH) drew attention to the persistence of slavery-like practices; at the same time, it pointed to efforts under the government's Strategic Framework for the Struggle against Poverty to reach descendants of slaves living in poor areas and facilitate their access to health and education services.

Slavery is reported to be most prevalent in the Hodh el Gharbi, Hodh ech Chargui and Trarza regions, where poverty, lack of education and adherence to a hierarchical tradition create conditions in which people continue to be enslaved, working in their masters' households or tending their herds.

While there is little data on the conditions of slavery, information received indicates that slaves often receive inadequate food and care; enslaved women and girls are particularly vulnerable to sexual violence.

Dozens of slaves have escaped or been freed since the 2007 law was passed, with most cases against their former masters being resolved outside of the courts or dropped due to pressure on the plaintiffs.

In November 2011 the first conviction was handed down, in a case involving the enslavement of two young boys. The accused was given a two-year sentence and ordered to pay compensation to the children; their lawyer appealed on the grounds that the judgment was too lenient. The owner was released on bail after four months' detention.

SOS Esclaves, founded in 1995, was deeply involved in the struggle to criminalize slavery in law in Mauritania. The organization now provides practical support and at times legal assistance to those escaping slavery, and works to combat the discrimination and social prejudices that underpin it.

On 29 April 2013 the 'Manifesto for the political, social and economic rights of Haratines' was launched by civil society organizations and Haratine community leaders. It calls for a nationwide effort to develop

a social contract for all Mauritians, and for the establishment of a structural mechanism, with a budget and a public reporting function, responsible for the effective eradication of slavery. It also urges progressive movement towards universal health insurance, and for a quota of 40 per cent Haratine representation in constitutional and administrative bodies.

Anti-slavery activists came under particular pressure in 2012 when seven members of the anti-slavery organization IRA Mauritania were arrested with their leader after he burned religious texts at a protest.

At least one demonstrator for their release died in June, reportedly due to the effects of tear gas used by the police. The activists were provisionally released in September; however, they reportedly continued to receive threats.

The international analysts who highlighted Mauritania's advances in electing women to posts of authority have noted that cultural barriers can still make it difficult for them to speak out, advocate for change or make decisions publicly – all essential steps in truly empowering women.

In the face of this situation, in 2012 MRG began implementing a three-year project on behalf of Haratine women, working with civil society organizations to improve understanding of the rights of women and the multiple forms of discrimination against them to help ensure that their work addresses the specific needs of Haratine women. The project also aims to improve the leadership skills of Haratine women through projects and grants. The trainees will then be supported in outreach work in their wider community, to challenge gender stereotypes and foster girls' and women's leadership at the grassroots level.

It is hoped that efforts such as this will contribute to much-needed change at the grassroots level in Mauritania. ■



Central Africa Burundi

While 2012 reportedly saw fewer killings than the preceding year, ongoing political violence between the dominant party, the National Council for the Defense of Democracy-Forces for the Defense of Democracy (CNDD-FDD) and opponents continued to threaten Burundi's stability. Widespread impunity remained a critical issue, especially concerning

members of the security forces and persons affiliated with the youth league of the CNDD-FDD. And journalists and civil society organizations continued to feel pressure, with draft legislation curbing press freedoms being proposed in the Burundi parliament in October.

After Tanzania revoked their refugee status and announced plans to close their camp by the end of the year, more than 34,000

Left: Batwa man in Burundi. *Ben Rodkin.*

Burundese refugees returned home in late 2012. Upon arrival they faced a Ministry of Health-declared national disaster: a cholera outbreak, which was particularly severe in returnee areas.

The situation of Burundi's Batwa people was one focus of the Universal Periodic Review (UPR) of Burundi's compliance with human rights standards by the UN Human Rights Council in 2012. Burundi's report stressed that its Constitution mandates respect for ethnic diversity, that the rights of all citizens are protected equally, and that it was implementing non-discrimination measures in favour of Batwa children, for instance by funding their secondary education.

During the review a number of UN agencies expressed concern about discrimination against Batwa with regard to access to land, education and employment.

Further issues were raised during the UPR process. Several NGOs drew attention to the fact that poverty remained more prevalent among Batwa than among other groups.

Other issues of concern during the review included the level of malnutrition among Batwa children, their lack of access to full medical treatment due to their families' poverty, and the inability of Batwa women to access maternity care due to lack of identity documents.

For its part, the United Nations Integrated Management Team in Burundi (UNIMT) expressed concern that medicines for chronic illnesses were not affordable for Batwa, among others. With regard to MDG 4, on reducing child mortality, and MDG 5, on reducing maternal mortality, Burundi had by 2010 made some progress; however it reported that it was not likely to meet the 2015 targets. With regard to MDG 6 on reducing infectious diseases, it reported that stopping the spread of HIV was improbable, but achieving goals in reducing malaria and other infectious diseases, on the other hand, was possible.

One of UNAIDS' 22 priority countries, Burundi achieved a moderate decline in new HIV infections among children between 2009 and 2011 (MDG 6).

Central African Republic

In the CAR, political divisions, tensions among ethnic groups and spillover conflict from neighbouring Chad, Sudan, the DRC and Republic of Congo have contributed to chronic instability.

In 2012 several discrete conflicts caused internal displacement and hampered humanitarian assistance to those affected. In the west and north-central areas, farmers clashed with nomadic pastoralists in search of grazing land for their livestock. In the north, the Chadian Front Populaire pour le Redressement (FPR) rebel movement operated despite joint efforts by both armies, raising tensions between Muslims, particularly those of Chadian descent, and other citizens.

LRA attacks, which had abated over previous months, resumed in January. By year's end, the UN signalled an increased LRA presence in south-eastern CAR, with nearly 50 separate attacks causing scores of deaths and abductions. Some of the LRA leaders wanted by the ICC on charges of crimes against humanity were believed to be operating from the CAR, and the threat of LRA attack seriously curtailed movement, disrupting farming, hunting and trade and exacerbating poverty.

In May the UN Secretary-General expressed particular concern about the vulnerability of the CAR's Mbororo, cattle-herding nomads, not only to LRA abductions for ransom but also to stigmatization by other ethnic groups who suspected them of being associated with the LRA because of their nomadic way of life. Mbororo have also reportedly been attacked by security forces and others mistaking them for Chadian rebels.

In December, an alliance ('*Seleka*') of dissident elements from three former rebel groups made rapid gains, securing key towns and threatening the capital Bangui; they accused the government of failing to honour promises made during earlier peace deals. President François Bozizé was overthrown in March 2013, after the rebels seized key government buildings including the presidential palace. A deal had been signed between Bozizé and the rebels in January 2013, but the rebels quickly began accusing the former president of renegeing on key aspects.

Health

Conflict and displacement make access to health care, already exceedingly poor in the CAR, even more difficult. Experts reported that the CAR faced a perpetual health crisis, with little international support. In 2011 the CAR had the second-lowest life expectancy in the world, at 48 years.

A survey by medical NGO Médecins sans Frontières (MSF) indicated that, alarmingly, children under the age of five accounted for almost half of all reported deaths in parts of the country. An update on progress towards the MDGs in Africa indicated that the CAR was one of the four countries in the region – all in or post-conflict – with the highest infant mortality rates; and one of the eight countries – again all in or post-conflict – with the highest maternal mortality rates. It was one of only seven African countries where immunization coverage declined between 1990 and 2010.

With the region's highest rate of HIV infection, the country faces what *The Lancet* described as an 'escalating HIV epidemic'.

According to its 2010 MDG report, the government judged it impossible to meet the 2015 target reductions in child and maternal mortality (MDGs 4 and 5). With regard to MDG 6, it reported that while stopping the spread of HIV was impossible, reducing malaria was possible.

Democratic Republic of Congo

The year 2012 saw an upsurge in fighting in eastern DRC; in November the UN reported an increase from 1.7 to 2.24 million internally displaced people over the year. An additional 70,000 people fled into Rwanda or Uganda.

Despite vast wealth in resources, the DRC ranks last out of 187 countries under the UNDP Human Development Index. The root cause of its misery is ongoing conflict and the state of humanitarian crisis it creates. This results in the highest rate of malnutrition in central and west Africa, affecting 43 per cent of children under five according to UNICEF. Treatable infectious diseases such as malaria, diarrhoea and acute respiratory ailments have become the most common causes of death for this age group.

A regional MDG update indicated that the DRC was one of the four African countries – all in or post-conflict – with the highest infant

Case study

Community health care succeeds for Batwa

As Rwandans enjoy rising life expectancy and falling disease burdens, marginalized Batwa remain excluded from mainstream health care. But now a community project is beginning to change attitudes.

In recent years, Rwanda has made impressive progress in combating poverty and inequality through inclusive economic growth. It has established universal health insurance and recorded a 40 per cent reduction in the infant mortality rate.

At the same time, Rwanda has taken steps at a policy level to address the inter-ethnic issues that led to the 1994 genocide. The Constitution rejects ethnic classifications; it commits itself to 'fighting the ideology of genocide' and to 'the eradication of ethnic, regional and other divisions and promotion of national unity'.

New laws have prohibited 'divisiveness' along ethnic lines. Experts have expressed concern that the non-recognition of ethnicity contravenes the individual's right to identify with a specific ethnic group, and ignores such groups' specific needs and situations.

The Rwandan state has recognized the particular challenges facing what it terms 'historically marginalized peoples', namely, roughly 33,000 indigenous Batwa. Traditionally forest-dwelling hunters and gatherers, over past decades they have been expelled from their ancestral lands without compensation to make way for agriculture or conservation.

Through discrimination and difficulties in accessing services, Batwa communities have largely missed out on Rwanda's progress, with the result that they have higher infant mortality rates, shorter average lifespans and



Above: A Batwa woman in Rwanda. *Eric Lafforgue.*

higher rates of disease and malnutrition than their neighbours.

In 2011, the Young Women's Christian Association of Rwanda (YWCA), a non-governmental, non-profit grassroots organization, developed a street theatre project as a way of challenging stereotypes and discriminatory attitudes against the

Batwa. Over two years, it reached about 52,500 people through community, market and street performances.

While preparing the theatre production, actors and staff spent time living in a Batwa community. This, explained YWCA Programme Officer Archimede Sekamana, was an eye-opening experience for the development workers, who saw straight away that the community 'needed more support than just changing the mindset ... you see

Case study continued

young 16-year-old girls with babies, you see the needs, and you think “How can I help them?””

YWCA staff began to search for ways to respond. In January 2013, a pilot Young Women’s Action Club was set up in a Batwa community in Gitarama. Eighteen young Batwa women have received training in reproductive health and family planning, with the aim of carrying out outreach work among other young women in the community.

Batwa women have also been included in the YWCA’s programme for HIV-positive women. Sekamana, describing the initial outreach effort, said, ‘in the Batwa community, we asked them how many knew about their (HIV) status. We realized that none had been to clinic or hospital to get tested ... we were looking for 50 women and found 200.’ YWCA is now working on HIV prevention education.

Fifty Batwa women have been incorporated into a project helping them develop skills in handicrafts or small businesses. The programme was initially set up to support children who had been orphaned in the genocide or whose parents were in prison on genocide charges. Batwa children, without an authority figure to advocate for them, were often left out. Now the project is trying to recruit young heads of households among Batwa families, such as those orphaned by HIV/AIDS.

International donors have cut some of the aid that makes up 40 per cent of Rwanda’s budget in response to reports that the government is supporting the notorious M23 rebels in neighbouring DRC, reports that Rwanda vehemently denies.

Meanwhile, quietly, groups like the YWCA, which have shown an impressive willingness to challenge their own mindsets as well as those of their beneficiaries, continue to make a genuine difference in the lives of extremely vulnerable people. ■

mortality rates; and one of the eight in the region – again all in or post-conflict – with the highest maternal mortality rates. It was one of only seven African countries where immunization coverage declined between 1990 and 2010.

The year 2012 saw health emergencies such as an outbreak of Ebola fever in Orientale province and an ongoing cholera epidemic.

HIV is also a serious issue, in part due to the high incidence of sexual violence in conflict areas. The DRC, one of UNAIDS’ 22 priority countries, was reported to have achieved ‘slow or no decline’ in new HIV infections among children between 2009 and 2011 (MDG 6).

In October, Dr Denis Mukwege, founder of Panzi Hospital in Bukavu, South Kivu, was temporarily forced into exile after narrowly escaping an attack by armed men outside his home. Dr Mukwege has become an international spokesperson against conflict in the DRC over the course of a career treating tens of thousands of women victims of sexual violence.

Indigenous groups such as Batwa faced difficulties with regard to health care; as conflict spread, discrimination and marginalization made it particularly difficult for them to access emergency humanitarian aid.

Upsurge in conflict

In April members of the armed group National Council for the Defence of the People (CNDP), which had integrated into the national army after a 2009 peace deal, mutinied. Some of them were led by Bosco Ntaganda, against whom the ICC issued arrest warrants in 2006 and 2012 for alleged crimes against humanity and war crimes. The mutineers subsequently formed themselves into the armed group M23.

In November M23 took the city of Goma in North Kivu, withdrawing in December to begin negotiations with the DRC government in Uganda.

During the course of the year’s confrontations, both M23 rebels and army soldiers reportedly committed mass violations and war crimes, including summary execution and rape, against the civilian population.

According to the UN and other sources, the M23 is directly backed by the Rwandan and

Ugandan governments, although both reject these allegations.

In the security vacuum formed in eastern DRC as some soldiers and police deserted to join the M23 and the remainder focused on fighting the new threat, existing armed groups have gained ground, at times carrying out ethnically motivated attacks in areas newly under their control.

The UN reported that at least 264 civilians were killed in more than 75 attacks on villages in Masisi, North Kivu between April and September. The attacks were said to have been committed along real or perceived ethnic lines, with the Democratic Forces for the Liberation of Rwanda (FDLR) and Mayi-Mayi Nyatura militia targeting civilians they considered to support the rival Mayi-Mayi Raia Mutomboki group, and the latter targeting ethnic Hutus they suspected of sympathizing with the FDLR. ■

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Alaska (US)

CANADA

NORTH
PACIFIC

UNITED STATES

ATLANTIC
OCEAN

Hawaiian Islands (US)

MEXICO

CUBA

DOMINICAN REP.

HAITI

Puerto Rico (US)

BELIZE

JAMAICA

GUATEMALA

HONDURAS

EL SALVADOR

NICARAGUA

COSTA RICA

PANAMA

VENEZUELA

COLOMBIA

GUYANA

Guyane (Fr.)

SURINAM

ECUADOR

PERU

BRAZIL

BOLIVIA

PARAGUAY

SOUTH
PACIFIC

CHILE

URUGUAY

ARGENTINA

Americas

Maurice Bryan

The immense and socially diverse Americas region has large populations of mixed ethnicity. These include immigrants from European, Asian-Pacific and Middle Eastern countries. There are tens of millions of distinct indigenous and African descendant peoples, some constituting more than 40 per cent of the total population of their countries.

It is the region with the world's greatest income disparity. According to the Economic Commission for Latin America and the Caribbean (ECLAC) over 35 per cent of the total population region-wide lived in poverty during 2011, with the ratio being considerably higher in some countries. In 2012, indigenous and African descendant populations continued to represent a disproportionate number of the poorest people and to experience the negative consequences of that reality on their overall well-being and especially with regard to their health.

According to the World Health Organization (WHO) at least 125 million people region-wide do not have access to health services. The very large population of indigenous peoples and African descendants in many states, however, suggests that their health concerns should rank among the main national priorities.

Nevertheless as a group, indigenous peoples in the Americas often have the worst health profiles. This includes the highest rates of morbidity and mortality, and the least access to health services compared to the rest of the population. Along with African descendants they continue to be the most institutionally under-served.

During 2012, land loss, national population growth, as well as the continued extension of agricultural, mining and energy generation initiatives – in Argentina, Bolivia, Brazil, Chile, Guatemala, Honduras, Mexico, Panama, Peru – continued to represent serious threats to health and well-being, and in some cases even continued community survival.

This was very evident among groups living in remote areas and forest zones, including those in voluntary isolation in the Amazon rainforest. In addition to losing their traditional means of livelihood, the voluntary isolationists remain particularly vulnerable to incoming diseases, to which they lack resistance. Historically such situations have had notably negative effects on

Right: A girl stands in a classroom in San Miguel, an African descendant community in Ecuador. *Ivan Kashinsky/Panos.*

the survival chances of earlier generations of indigenous peoples across the hemisphere.

Regional health concerns

A general lack of socio-economic and general data disaggregated by both ethnicity and gender in most of the countries of the Americas, makes it difficult to draw really precise conclusions. Nonetheless, important similarities between indigenous peoples across the countries of Latin America do exist, especially in the health sector.

In 2012, among the major basic health concerns for African descendant minorities and indigenous peoples – especially in Central and South American states – were continuing high infant and maternal mortality numbers, inadequate nutrition, a high incidence of diarrhoeal and respiratory diseases, as well as vector-borne diseases such as dengue fever and malaria.

In addition, during 2012 the effects of changing diet and life patterns among indigenous and African descendant people remained a source of concern for community leaders and public officials in both rural and urban areas of the continent.¹

This is with special reference to the rise in the incidence of non-communicable chronic diseases such as diabetes, hypertension, cardiovascular dysfunction and cancers (breast, colon and lung) in these populations. Hitherto, these have tended to be associated with non-traditional mainstream urban industrial mass-consumption living patterns. However, health officials note that both the prevalence of diabetes and mortality are rising higher in minority populations – in Mexico and the USA – particularly among those who are less physically active, less educated and with lower income levels.

Along with changing consumption patterns, part of the disease rate rise (especially cancers) can also be attributed to increased exposure – both as residents and as workers – to toxins in mineral resource extraction and agro-industry zones.

Factors such as inadequate working conditions,



pesticide and toxic materials run-off, mining effluent, diversion of water sources and pollution of groundwater were all causes for concern among both community residents and health officials from Alaska to Argentina.

Climate change

Adding to health and well-being challenges during 2012 were environmental factors increasingly attributed to climate change. Unprecedented floods, droughts, and the melting of glaciers and Arctic perma-frost threatened physical safety and food and nutrition security – and, by extension, overall health (in Bolivia, Canada, Costa Rica, El Salvador, Guatemala, Honduras, Mexico, Peru, the United States).

Often this was linked to the remote, marginal and rural locations of the vulnerable populations,

and a general reliance on subsistence economies that are closely tied to natural cycles and weather patterns.

Traditional remedies

One result of historical and current marginalization has been the need and also the desire of these populations to retain a degree of self-sufficiency in the area of health, through continued use of traditional methods of healing and medication. In recent years the effectiveness and sound underlying curative principles of some traditional methods have been increasingly recognized by state health authorities across the region.

Apart from Cuba, Honduras and Venezuela – which make no legal allowances – most regional states have taken steps to formally

recognize, validate and incorporate indigenous traditional medicine into mainstream health services. This includes providing training courses in traditional medicine to health professionals and incorporating female traditional birth attendants into the formal health system.

Security issues

Of special concern also from a health perspective during 2012 was the ongoing high level of public insecurity (Brazil, El Salvador, Guatemala, Honduras, Mexico) as well as protracted armed confrontations (Colombia, Mexico). All too frequently the zones affected are inhabited by indigenous and African descendant populations.

These conflicts continued to result in high homicide and disappearance rates, as well as firearm injuries – especially among young males. None of this was lessened by the continued and arguably still growing influence of human and narcotics trafficking and other organized criminal activity on state institutions, sometimes affecting judicial impartiality and other functions of state apparatus.

When combined with extra-judicial killings of rights defenders and journalists (Honduras, Mexico) as well as corporate harassment of peasant farmers and environmentalists (Colombia, Guatemala, Honduras, Mexico) the threats these all pose to physical and especially mental health can be significant.

This is true of rural areas as well as overcrowded low-income urban zones where marginalized indigenous and African descendant populations tend to gravitate and sometimes be predominant, and which are very prone to exploitation by armed criminal gangs.

The constant feelings of public insecurity can contribute to high stress levels, anxiety and trauma. When combined with the range of socio-economic challenges it all can take a significant – and sometimes institutionally overlooked – toll on the mental health of these vulnerable groups.

Mental health

There is a notable lack of research on the mental health of indigenous peoples; consequently statistics are virtually unavailable. Despite the launching of the Pan-American Health

Organization's Health of the Indigenous Peoples Initiative 16 years ago, mental health services designed for indigenous peoples' special needs have yet to be created.²

In 2012 however, mental health issues within vulnerable African descendant and indigenous communities continued to be of particular concern region-wide. This is especially as they relate to alcohol and substance abuse, chronic depression, intra-family violence, and the high suicide rates among young people in the marginalized indigenous communities of Canada, the United States and the Mato Grosso region of Brazil.

Bolivia

In Bolivia, according to the national census some 71 per cent of the population is considered to be indigenous. During 2012, resource extraction continued to be a major factor in national life, affecting the economy and also the general health of the population.

The US\$2.642 billion Bolivia earned from mining products in 2010 represented about 22 per cent of the overall national GDP. However, according to the ECLAC the state spent just 4.8 per cent of GDP on health, one of the very lowest expenditures in the Americas region. The limited expenditure means that some areas – especially rural and indigenous – have no health clinics or access to doctors or nurses.

Nevertheless, Bolivia's historically marginalized indigenous population makes up the bulk of the approximately 79,000 employed – both formally and informally – in the mining sector. Their health and well-being, therefore, are closely tied to these activities.

Mining sector health is not related solely to extraction issues. It can also be influenced by social and political factors like the ongoing mine nationalization that began in 1952. In January 2011, the Bolivia government reported 29 unresolved – and sometimes violent – conflicts involving cooperative and unionized mining workers. According to BBC reports, one such dispute over ore access rights at the recently nationalized Colquiri mine caused injuries and death during 2012. Rival groups of miners signed a deal that ended the clashes in September.

Mining and community health

In addition to unionized miners directly employed by the state-owned mining corporation, COMIBOL, there are about 650 private cooperative mining groups nationwide, employing 75,000 people. In 2012 they helped make Bolivia the world's sixth largest producer of tin.

With global tin prices at an all-time high, there is a boom in places such as Potosi and Huanuni in the department of Oruro. Critics claim the tin rush is extracting a heavy toll on the health and social fabric of the community. Local sources indicate that the population of Huanuni has now more than doubled from the 15,500 of just a few years ago. This has prompted many changes in the overall social and environmental health situation – with special consequences to those local women who are dependent on wage-earning males. The severe air pollution from mining and tin smelting can cause watery eyes and running noses after just three hours of exposure. The tin extraction tailings continue to be discharged into the nearby river, turning the waters black.

Given the long history of tin mining in the Bolivian *altiplano*, a particular indigenous health concern across many generations has been the effect of free crystalline silica. It is the most abundant compound in the earth's crust and the most common element in the dust that Bolivian mine workers inhale.

According to the International Labour Organization (ILO), prolonged silica exposure can produce silicosis. This is a respiratory ailment that can cause shortness of breath, coughs and fevers within months, and significant impairment or death within a few years. Silica exposure is also associated with an increased risk of fluid in the lungs, tuberculosis, lung cancer and some autoimmune diseases such as rheumatoid arthritis. The mining-related population spike in Huanuni has not only increased the overall spread risk of communicable pathogens such as tuberculosis but also of socially related diseases such as HIV and hepatitis (B and E). The rapid population boom has also created environmental health risks arising out of a surplus of rubbish, which ends up in the local river.

As well as large mining operations, there are many small indigenous family-run zinc, silver and tin mines in the *altiplano* region. In addition to

male miners, these are also worked by indigenous women and by adolescents and children.

According to UNICEF, under-age miners constitute some 10 per cent of the total Bolivian artisanal mining workforce.

Thousands of indigenous women and under-age artisan miners work up to 14 hours a day on mountainsides and deep underground in extremes of heat and cold. Consequently, like male miners, women and children in Bolivia are also exposed to mining-related health risks, especially silicosis.

Women in the Bolivian mining areas are sometimes doubly affected, by both health risks as miners and the social consequences of any town becoming a mining boom town.

Members of a local women's support network in Huanuni were especially concerned during 2012 about the social effects of the boom on indigenous women, particularly with respect to the relationship between over-indulgence in alcohol and violence (physical, sexual, psychological) against women.

Government legal services do exist for victims of domestic violence and neither Bolivian law nor authentic traditional indigenous culture tolerate such behaviour. However, violence against women is endemic. According to the female doctors at the Huanuni health centre, around six cases of domestic violence are treated each weekend – some with injuries that require hospital attention. Sexually transmitted diseases, cervical cancer and AIDS are also evident among the town's indigenous female population.

In a country where, according to the ECLAC, the maternal mortality rate is 190 per 100,000 live births, the doctors are also concerned about the health consequences of high teenage pregnancy rates in the boom town. About half occur among those under 15 years of age, with some 19-year-olds on their third pregnancy.

According to the NGO Development and Peace, during 2012, local environmental organizations succeeded in having the government declare Huanuni an environmental emergency zone. The government indicated that it will promote plans, programmes and projects to address the negative aspects – for the environment and the population – of the mining upsurge in the Huanuni area.

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Case study
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Bolivia: Traditional healers and climate change

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As elsewhere in the indigenous Americas, there is a very significant distrust of formal mainstream medicine among Bolivia's largely indigenous population and a particularly strong preference for traditional medicine. National surveys by the Ministry of Health indicate that 60 per cent of Bolivians turn to natural prescriptions before going to a modern physician. This occurs even in zones with some access to formal health services, such as southern Cochabamba, where over 55 per cent of the population continues to prefer to use traditional medicine.

During 2012, efforts continued to integrate the practices of modern health professionals with those of traditional healers.

There are three main categories of traditional healers: *Hechiceros*, *yatiris* and *curanderos*. *Hechiceros* and *yatiris* deal primarily with mental disease and the environmental, psychological, social and cultural causes of disease. The *hechiceros* cure by joining the patients in a special ritual with members of their family and their community. *Curanderos* are the medical practitioners who deal with physical disease and specialize in herbal curing.

Of all traditional health care providers, the most renowned are *kola-waya* ('he who carries medicines in his shoulders'). These travelling healers are more commonly known as Kallawayas and they journey extensively on foot all over Bolivia as well as throughout Argentina, Chile, Ecuador and Peru, reaching as far north as Panama during the canal-building era of the early 1900s.

Villagers across the Andean area have a deep respect for their knowledge and skills. These are usually passed down through successive generations using a special esoteric language

called *Machai Juyai*, known only to Kallawayas, which is thought to date from the Inca era.

Like other traditional healers from Andean region countries such as Ecuador and Peru, the Bolivian Kallawayas share a common worldview which is based on respect for Mother Earth (*Pachamama*) and the need for humans to live in harmony with their environment.

Another manifestation of the overall Andean cosmovision, and one of the main tenets of the Kallawayaya practice, is the ethic of 'reciprocity' or mutual exchange. This is considered to be equally applicable to people, communities and the environment as a whole. Preventative measures and health maintenance are therefore based on the idea that humanity must remain in balance with the environment.

Consequently, Kallawayas use various medicines and rituals to restore equilibrium to the person and their environment, and thereby ensure harmony between the two.

Bolivia's Kallawayas traditionally live in the province of Bautista Saavedra, north-east of the world's highest lake – Lake Titicaca. This region has a unique ecosystem situated at the interface between the high peaks of the Cordillera Apolobamba and the lowland semi-tropical climate of the Yungas.

The villages of the Cordillera Apolobamba constitute the heartland and home base of the centuries-old Kallawayaya healing tradition and the distinctive geography plays an important role in this.

The mountains are considered to be the home of spirits that protect those living near them. The communities are often located on the steep sides of the mountains and are usually divided into three altitudes, each one growing certain crops using terrace-style agriculture.

While the communities depend on the various agricultural zones for food and medicine, they also symbolize the structure of the human body. The higher levels are thought to represent the head of the human body, with the central and low levels representing the trunk and legs respectively. This division governs daily life in the communities and also underscores the complex interconnection between the land, the communities and the people that live there – including the Kallawayas.

Climate change

However, ongoing changes in climate are now threatening the survival of traditional indigenous communities throughout the Andean region, and by extension the continuation of the art of Kallawayá healing.

Many of the glaciers in the high Andes are now rapidly melting, and many of these are located in this Bautista Saavedra region. The changes are causing great concern to Kallawayá healers both from a practical physical as well as metaphysical perspective. The melting high glaciers – once considered a permanent part of the landscape –

have great symbolic meaning as well as practical consequences for the lower-lying communities that make up the three levels of the human/cosmic body.

Since Kallawayá healers see people as inherently linked to the land, the rapid disappearance of the glaciers (located at the head) does not bode well for the future of the body.

Return and revitalization

Although the Kallawayá healers are known to visit places as far distant as Panama, they regard the villages around the Cordillera Apolobamba as their physical as well as spiritual home base. After their extensive travels it is important for them to return to Bautista Saavedra in order to maintain their farms and to ‘recharge their spiritual batteries’.

However, the changes in climate are unprecedented in the thousand-year experience and legacy of the Kallawayá tradition. They claim the dry season is now longer and dryer, which makes the wet season much shorter. The river that runs past the villages is now almost dry.

For Kallawayá healers, who depend on agricultural and herding activities, the dried-out river and the seasonal changes are especially threatening, both in terms of physical survival and of spiritual sustenance. In accordance with the integrated nature of the Kallawayá cosmovision, the decline of the environment is directly linked to a weakening of the physical and spiritual well-being of the communities that live there, including the crops they grow. They claim that the unpredictable and shorter seasons directly affect the quality of local agricultural products, which in turn has an impact on the art of healing since balance is central to sustaining overall spiritual and physical health and well-being.

Local healers point out that in recent years the all-important potato harvests have been coming in earlier, and other crops are also being affected. Moreover, while the food may look and taste the same to those unconnected with the healing



Left: Kallawayá healer from Bolivia holds up a curative plant. REUTERS/David Mercado DM/VP.

Case study continued

tradition, Kallawayas are concerned that the environmental imbalance is causing a loss of key vital forces, thereby diminishing the spiritual content of the food itself. These vital forces they hold to be important in maintaining the spiritual energy of their communities and, by extension, their own personal spiritual vitality.

There are other social factors that Kallawayas view as being detrimental to the overall equation. The crop cycle changes and overall environmental degradation have added to the contemporary lure of urbanization that is causing many young people to abandon the hillside communities to seek education and work in the cities. Houses are left to crumble and the thousand-year-old mountain terraces in the high Andes left untended, further diminishing the chances of cultural continuity.

The overall reduction of human and environmental energy on which the Kallawayas depend for the effectiveness of their healing rituals and ceremonies means the ability to carry on their work is also at risk. This is threatening the legacy of healing knowledge and practices as well as the ancient and vital art of Kallawayas healing itself – which in 2008 was included by UNESCO as a Representative of the Intangible Cultural Heritage of Humanity.

Such a disappearance would mark the loss not only of a very important and cherished cultural tradition but also the curtailment of a highly regarded source of health care for thousands of indigenous people all across the countries of the Andean region who continue to depend on the travelling Kallawayas healers for their physical and spiritual health and well-being. ■

Brazil

During 2012, violent disputes continued on ancestral lands claimed by indigenous peoples in the state of Mato Grosso do Sul in south-west Brazil. It is home to some 44,000 Guaraní-Kaiowá, the second largest indigenous group in Brazil.

According to local media, having grown weary of being encamped along the roadsides waiting for the Brazilian government to demarcate their ancestral territory, the indigenous Guaraní-Kaiowá community of Pyelito Kue/Mbarakay occupied a small part of their lands, which had been taken over by large-scale farmers and ranchers. When ordered by the court to leave in October, the Guaraní publicly threatened to engage in mass suicide to protest their continuing dispossession.

The threat attracted global attention and highlighted the worsening conflicts over the ongoing invasion and occupation of indigenous territories in Brazil. For over a decade expanding cattle ranches and the agro-industrial cultivation of Brazil's two major biofuel-related export crops have pitted indigenous groups against landholders in the Mato Grosso region on the Brazil–Paraguay border.

Indigenous efforts to regain their dispossessed territories include occupations and there have been armed confrontations with landholders. The continuing armed attacks by local landowners, coupled with the October 2012 court ordered eviction, prompted 30 Pyelito Kue Kaiowá community families to announce their 'collective death' if they were driven off the land.

For over a week between late October and early November 2012, activists in Brazil mobilized protests in support of Guaraní-Kaiowá resistance in several of the main cities. Street demonstrations were also mobilized internationally, including protests in Germany, Portugal and the United States.

Faced with the growing and very public local and international clamour, the Brazilian government ordered the court ruling revoked. This allowed the Pyelito Kue Kaiowá families to stay where they were until the demarcation process is completed.

The Brazilian government has recognized indigenous rights to 9,317 hectares of

Guaraní-Kaiowá community territory since 2005, however actual possession has been delayed by litigation and negotiations on landholder compensation. Since 1991, only eight reserves have been formally approved.

The ongoing delay has left the way open for takeovers by those seeking to enlarge their landed estates. Moreover, the state government has strongly supported agribusiness. This has only served to sharpen the conflict.

According to a study by the Brazilian NGO Repórter Brasil, the expansion is partly fuelled by rising international commodity prices for crops such as soy beans or sugarcane. This is prompting an increase in demand for arable land, which then leads to more communities being forced off their territories.

Land and health

Given the importance of land to indigenous cultural survival and mental health, the ongoing dispossession is taking a heavy toll. According to the Catholic Indigenous Missionary Council (CIMI), the rates of malnutrition, suicide and violence in Guaraní-Kaiowá communities are extremely high.

The Kaiowá are a nomadic people who have traditionally migrated in search of ‘the land without evil’ and there is a significant history of suicide, particularly among young people, in Kaiowá and other Guaraní groups. A total of 555 suicides between 2003 and 2010 in Mato Grosso indicates a suicide rate of nearly 80 a year (out of a population of 44,000 Guaraní-Kaiowá in the region).

Additional health concerns are directly connected to the large-scale agro-industry, including the intensive use of pesticides in the Guaraní-Kaiowá areas. This aggravates the destruction of rivers and forests that have traditionally represented indigenous hunting and fishing food survival sources.

Although the working conditions on large estates or in sugarcane ethanol biofuel plants are less than ideal, the increasing move towards agricultural mechanization in Brazil and the use of toxic chemicals is reducing even these employment opportunities for indigenous peoples. For many, dependence on government assistance is the only other available income option.

Boycotts

In an effort to stop transnational corporations from purchasing commodities from estates illegally located on disputed indigenous lands, the Brazilian NGO Repórter Brasil launched an international boycott campaign. However, evidence suggests that companies will continue buying these products as long as they think estate holders are not legally compelled to relinquish the occupied lands.

During 2012, the federal government promised to speed up the demarcation process; however farmers and ranchers continue to demand economic compensation for having to vacate indigenous territory.

Belo Monte

During 2012, protests continued in efforts to halt construction of the controversial Belo Monte dam, which is the largest in a number of contested energy expansion projects on indigenous territory in Brazil. Actions included a 21-day occupation of the site in late June and in July. Indigenous activists detained and later released three of the building engineers.

Of enormous significance to Belo Monte protesters and critics was the unanimous legal decision to cease all project construction issued by Brazil’s federal regional tribunal of the first region (TRF-1) on 14 August 2012. Judges cited the lack of prior consultation with indigenous peoples affected by the massive hydroelectric project. The August ruling upheld an earlier 2005 court decision.

Nevertheless in late August 2012, in response to a complaint filed by the government, the Chief Justice of the Brazilian Supreme Court overturned the suspension, arguing that stopping construction of the dam would cause social and economic chaos, including the dismissal of some 14,000 workers. Construction resumed almost immediately. The Federal Public Prosecutor’s Office appealed the decision and demanded a review by the Supreme Court. A further large-scale occupation took place in October, temporarily halting construction. In November, the Brazilian National Development Bank (BNDES) announced a loan of approximately US\$11 billion towards the construction project; a first disbursement was made in January 2013,



despite the ongoing legal process.

Indigenous groups have protested the giant Belo Monte dam project on the Xingu River, claiming that it would pose a great risk to their health and well-being. In addition to being a source of their livelihood and sustenance they regard the Xingu River as a living entity.

Colombia

In an effort to end the long-running internal conflict, at the end of 2012 the Revolutionary Armed Forces of Colombia (FARC) began formal peace negotiations with the Colombian government in Cuba. This is to be followed by talks between the government and another major insurgents' group, the National Liberation Army (ELN).

Nevertheless, indigenous and Afro-Colombian activists report that while military combat may have lessened, Colombia's various far-right paramilitary 'gangs' continued to operate and expand in their regions, even while the presence of other armed groups was diminishing.

During 2012, Afro-Colombians and indigenous peoples continued to be removed and dispossessed of their ancestral lands by these paramilitary entities. Instead of conflict

and agribusiness expansion, the latest round of displacement and rights violations is linked to the rapid expansion of the mining sector in the Colombian economy – including illegal gold mining.

Mining fever

Colombia is now a major international producer of coal, nickel and gold. According to the Ministry of Mines and Energy, about 4 per cent of the national territory has been leased out for mining concessions. Moreover there is a pending backlog of 20,000 unprocessed title requests that cover approximately 20 per cent of Colombia's overall land area. Many of the sought-after concessions affect indigenous and Afro-descendant lands, which combined constitute a total of 91 million acres (or 37 million hectares).

According to ECLAC data, the mining and petroleum sectors provided almost 50 per cent of the country's total exports (US\$8 billion) in 2010. However, this sector, with its multiple social and environmental questions, contributed just 6 per cent to the total GDP in a country that spends 7.6 per cent of its GDP on health.

The Colombian NGO Dejusticia argues that the country is undertaking mining with very little

Left: An indigenous man participates in a protest against the construction of the Belo Monte hydroelectric plant in Brazil. *REUTERS/ Ueslei Marcelino.*

regard for the enormous social and environmental costs to the nation, and especially to indigenous and Afro-descendant communities.

The UN refugee agency UNHCR has cautioned that the rapid expansion of mining directly threatens the territorial rights, overall health and economic well-being of indigenous and Afro-Colombian communities, who make up over 30 per cent of the national population.

Mining in proximity to their lands has greatly increased the risk of related health hazards. These range from environmental problems to deaths and injuries due to title disputes and forced displacement by encroachers.

At issue is the fact that although some territories in question may be legally titled to the respective communities, under Colombia's 1991 Constitution the state retains the sub-soil rights for mineral and petroleum resources, which officials can allocate as they choose.

In May 2011 a newly introduced Mining Code (Law 1382) was challenged by Colombia's Constitutional Court. It had excluded the constitutionally guaranteed right to prior and informed consent regarding any activities occurring on indigenous and Afro-Colombian territories. The government then proposed amendments before re-tabling the legislation. The new draft favoured large – mostly foreign – mining companies and allowed already protected environmental and ethnic territories to be used for strategic mining projects.

About half of the gold produced in Colombia is extracted by small-scale and artisan miners and increasingly also by illegal prospectors. During 2012 incursions onto ancestral areas by individuals bent on illicit gold mining generated tensions in the Amazon as well as the southern Pacific coast region near the border with Ecuador.

Indigenous and Afro-Colombian communities complain that illegal miners ravage the jungle earth to get at the gold. Then they move on, leaving behind a series of polluted wastelands the size of football fields, littered with slag heaps and

pits of contaminated water. These areas contain highly toxic chemicals such as mercury.

In addition to land conflicts between armed entities and the respective communities, during 2012 the limited state presence in remote areas also encouraged violent disputes among the various paramilitary factions themselves, as well as between private investors, guerrillas, narcotics producers and the military, who are all increasingly interested in gold speculation.

According to local MRG partner CIMARRON (the *Movimiento Nacional por los Derechos Humanos de las Comunidades Afrocolombianas*), community members are often threatened with expulsion and violence if they resist encroachment. Moreover there is frequently an overlap of areas where displacement has occurred and where mining licences have been applied for or granted.

As well as gold exploitation the increase of open-pit coal mining in Colombia also had an effect on the well-being and health of Afro-Colombian and indigenous communities.

In February 2012 a protest over pollution caused by the massive coal mining in the north-eastern Colombian zone of El Cesar blocked the railroad used to carry trainloads of coal to the port of Santa Marta.

El Cesar sub-soil coal mining required the removal and relocation of the Afro-Colombian population from their ancestral territory to other areas. This included an obligation to provide new housing and public services – including schools. The residents complained there had been no prior consultations on the mining initiative, and coal mining had destroyed vast areas of productive land as well as the region's Calenturitas River. Moreover, the companies had not fulfilled the obligations to relocate their populations and provide basic amenities.

Likewise in La Guajira, the indigenous Wayúu community protested during 2012 over large-scale coal mining occurring at the giant open-pit facility at El Cerrejón, which exports over 30 million tonnes of coal annually.

Apart from not having consented to mining on their territory, the main reason for the El Cerrejón protests is the resulting poor air quality, which causes respiratory health problems. They also claim that the groundwater in their springs

and wells is now contaminated, and that there have been soil and forest losses. This is partly connected to the reality that mining 1 tonne of coal leaves behind 10 tonnes of slag and waste materials that continue to leach into rivers and the ground.

Ecuador

Although health services continue to improve, the access to mainstream health care by Ecuador's indigenous populations still presents challenges – especially for rural populations in the Andean and the Amazon regions. This includes lack of available health centres in or near indigenous communities, and inadequate access to medication. According to the Pan-American Health Organization (PAHO), Ecuador's health services are concentrated in urban centres while indigenous and Afro-Ecuadorian communities are often isolated and sometimes only accessible by boat or forest and mountain footpaths. This makes emergency care almost impossible.

Traditional medicine

Some indigenous Ecuadorians are unwilling to make use of the services that actually exist. According to researchers, indigenous Ecuadorians in the Andean region regard health in the context of harmony between body, mind and environment. Under these circumstances they are much more likely to place greater confidence in their communities' own traditional medical practitioners and use them as their first option.³ According to WHO studies, during such consultations the traditional healer will usually determine whether the illness requires therapy by rituals and ceremony and traditional medicines or a visit to the 'hospital doctor'.

Traditional medicine practitioners in Ecuador are unregistered and there is no licensing procedure; however associations of indigenous practitioners exist at regional and local levels.

According to the WHO, up to the early 1990s, Ecuadorian law limited the practice of medicine only to persons holding qualifications from the University of Ecuador. Under the new more culturally inclusive Constitution, however, recognition and regulation of traditional indigenous medicine came into force in August 1998. Included are stipulations that

Right: Q'eqchi' Maya girl holding her baby sister, Guatemala. *Sean Sprague/Panos.*

the state acknowledge, respect and promote the development of traditional medicine, monitor its application and legally control the operation of traditional medical practitioners.

This includes the right to the protection of ritual and sacred places, plants, animals, minerals and ecosystems of interest from the point of view of traditional medicine.

Unlike other Andean countries, there are no specific programmes in Ecuador linking traditional with formal mainstream medicine. Nevertheless, the state has been focusing more attention on official linkages including conducting courses for indigenous traditional birth attendants.

Amazon headache

In Ecuador, health issues that affect indigenous peoples can sometimes be linked directly to the economic sector. This is no more evident than in zones with resource extraction in the Ecuadorian Amazon and in the long-running legal drama connected with the giant Chevron-Texaco oil spill.

After 19 years of litigation, in October 2012, the US Supreme Court rejected a bid by Chevron to reverse a negative appeals court decision earlier in the year. In January, the 2nd US Circuit Court of Appeals in New York had overturned an earlier ban on enforcement of an Ecuadorian decision against the company. Meanwhile, damages in the case were increased to US\$19 billion by the Ecuadorian judiciary. The suit was originally filed nearly two decades ago on behalf of 30,000 indigenous and *mestizo* plaintiffs from some 80 Amazon communities.

Substantial evidence – including thousands of contamination samples taken by the company – prove that Texaco (which Chevron absorbed in 2001) was responsible for significant pollution and environmental devastation in the rainforest of north-eastern Ecuador (see SWM 2012 for more details of the case).

From the human perspective, this seriously affected the economic and cultural base of the local indigenous communities, and especially their immediate and long-term well-being and



health. The levels of hydrocarbon concentrations in some streams was as much as 280 times higher than European Union permitted levels.

According to sworn statements filed by the plaintiffs, some residents contracted skin rashes while others experienced vomiting and fainting. They also claim children have died from unknowingly drinking contaminated river water.

Studies have detailed the impact of oil development on the health of people in the Ecuadorian Amazon. There is a higher risk of health problems developing among residents who live near oil fields. Based on national population characteristics, higher than expected cancer rates have been found in the oil-producing village of San Carlos.

In another study published in the *International Journal of Occupational and Environmental Health*, a connection was found between higher spontaneous abortion rates and living in the proximity of hydrocarbon-contaminated water streams.

In the original decision, the Ecuadorian judge allocated nearly US\$1.4 billion for health care. In addition, US\$800 million is to be used for establishing a long-term health fund, US\$5.4 billion is to be used for soil restoration and

US\$600 million for clean-up of groundwater. By year's end, the plaintiffs were seeking enforcement in jurisdictions where Chevron does business.

Meanwhile, with the case still not settled and the health problems ongoing, Amazon indigenous communities continued to see multinational hydrocarbon prospectors cut through their ancestral lands in search of the vast petroleum resources.

In December 2012, the Ecuadorian government launched an international bidding process for large-scale oil exploitation in Ecuador's south-east Amazon region. According to indigenous leaders, most of this lies within ancestral territories of Achuar, Shuar, Huaorani, Kichwa, Shiwiar and Záparo indigenous communities.

Guatemala

Guatemala has an overall population of 15 million, of which close to 40 per cent identify as indigenous according to official statistics. This includes Maya, Garifuna and Xinca peoples. However, indigenous rights activists put the indigenous figure closer to 61 per cent – a majority. Seventy-five per cent of indigenous

Guatemalans live in rural areas, and studies point to a close relationship between location, poverty, ethnicity and poor health.

Fifty-four per cent of Guatemala's population lives in poverty and 13 per cent in extreme poverty. According to the ECLAC, the per capita GDP in 2011 was US\$2,303.90. Of that, the state spent 6.9 per cent on health. In real terms this puts Guatemala among the countries with the very lowest expenditure on health in the Americas. Moreover, health resources remain concentrated in urban centres even though 60 per cent of the total national population lives in rural departments.

Studies by the PAHO, have found that the rural departments with the highest concentrations of indigenous peoples display the greatest poverty and extreme poverty indicators, and the poorest health figures. According to the 2011 national survey of living conditions, the overall Guatemala health profile is among the very worst in the western hemisphere.

Painful realities

In 2012, many indigenous communities still lacked access to clean water, adequate sewerage systems, electricity and paved roads. According to the PAHO, less than six per cent of indigenous communities had access to drinkable water.⁴

To compound the problem, according to the ECLAC in 2010 only 15.4 per cent of mostly indigenous rural households had a sewerage connections compared to 68.4 per cent of mostly non-indigenous urban households. According to INCAP, 79 per cent of indigenous people still used outdoor toilets.⁵

Health professionals conclude that the high incidence of diarrhoea and other intestinal problems among Guatemala's indigenous majority is directly related to the poor quality of water supply and sanitation in indigenous communities.

The PAHO indicates that among multiple implications of this for female health is that carrying heavy loads of water over long distances places strains on women's musculo-skeletal systems. In addition, unsafe water means their families are more prone to intestinal and bacteria-borne diseases.

There is also a high incidence of respiratory

infection among indigenous women. This is partly because most indigenous women still cook and heat with firewood rather than gas or electricity. Most houses lack adequate ventilation systems. Only 4 out of every 100 indigenous houses had electricity in 2010 compared to 94 per cent of all urban households. Like the hauling of water, having to carry heavy bundles of fuel wood over long distances also contributes to muscle strains and back problems.

Health and income

The issues of poverty and health have strong links to income levels. In Guatemala, half of the indigenous population (nearly 5 million) continues to be employed in low wage-agriculture.

In 2012, Maya K'iche' activist groups such as Waxaquib Noj indicated that, along with poor pay, the working conditions endured by rural indigenous people continued to leave much to be desired. During the export-oriented coffee or cane harvests, workers live in rough shacks or sheds and sleep crowded together on the floor. These crowded living conditions aid the spread of communicable diseases, particularly respiratory infections such as the often lethal tuberculosis.

Many rural indigenous people survive tenuously on subsistence farming. Rural indigenous women are usually responsible for farming communal holdings.

A historical pattern of – sometimes forcible – land dispossession for agro-industry is a major factor in the continuing disparity between the indigenous population and the rest of Guatemalan society. It is clearly reflected in the area of food sovereignty and health.

During 2012, the Guatemalan Coordinating Committee of NGOs and Cooperatives (CONGCOOP) pointed out that over the last 22 years, the expansion of officially promoted export-oriented monoculture agro-industry and extractive enterprises have forced many rural families to sell their plots of land, leaving them hemmed in on all sides by African palm plantations and polluted water sources.

The National Institute for Agrarian and Rural Studies in Guatemala City estimates that between 2005 and 2010 the area of Guatemala given over to palm oil plantations increased by 146 per

cent. As reported in SWM 2012, much of the land acquisition was conducted under arguably questionable circumstances.

Studies by the PAHO indicate that the limited access to land for indigenous female-headed households in Guatemala – coupled in recent years with unprecedented droughts and floods – is largely responsible for a significant malnutrition problem among Guatemala's indigenous Maya children and women, leaving them more vulnerable to illness.

According to the PAHO the prevalence of chronic malnutrition among indigenous Maya children aged five and under was 58.6 per cent in 2008–2009, almost twice the 30.6 per cent rate of non-indigenous children.

Reforms fail

Despite earlier government assurances of change, in late November 2012 an 'integral rural development law' to promote access to land, clean water, soil conservation, food security, financial services, employment and other rights for small rural farmers was once again defeated in Congress. According to IPS News, the bill was defeated due to fierce opposition from large landholders and their Chamber of Agriculture, who see it as an unwelcome attempt at land reform.

Eighty per cent of Guatemala's fertile land now lies in the hands of barely 5 per cent of the population, according to the United Nations Development Programme (UNDP). Meanwhile 80 per cent of the overwhelmingly indigenous Mayan rural dwellers who represent some 61 per cent of the total population remain poor and landless.

Urban indigenous health

In urban areas the majority of indigenous people are either self-employed in the informal sector or run small businesses. Large numbers of indigenous peoples are employed by the export-processing factories known as *maquilas*, where women make up 80–90 per cent of the labour force, with 54 per cent being between the ages of 15 and 25. Most of this urban employment is low income, demands long working hours and does not provide access to any health insurance, social security or legislative protection.

A significant factor in the issue of disparity

between the majority indigenous Maya population and the rest of the society – including in the area of health – is racism and discrimination. According to the *Guatemala Times*, a November 2012 study conducted by a government commission and a local NGO on workplace discrimination and racism found that more than half of the business owners interviewed admitted paying indigenous people less for their services.

In the various types of urban work where indigenous Maya women are employed they often suffer physical and sexual abuse while receiving just 43 per cent of men's wages. Indigenous women's long working hours, combined with their multiple tasks in relation to domestic responsibilities, can result in chronic fatigue, high stress levels, headaches and frequent colds, as well as other symptoms.

Unhealthy trends

While indigenous people in urban areas may have better access to health services the opposite holds in rural zones where indigenous Maya populations numerically predominate.

At the primary level of care indigenous people must depend on rural health personnel. Travelling physician visits are infrequent. In these rural departments most indigenous Maya communities are remotely located and lack transport services. Getting to a clinic from an isolated village can sometimes entail a sun-baked four-hour walk.

Even when indigenous people do have access to health centres the service is less than ideal. Among the main problems – besides poverty – are ethnic and class discrimination. This especially affects indigenous women, many of whom steadfastly continue to wear traditional Mayan clothing.⁶

In a society that favours a mainstream Latino culture, activists point out that many indigenous Maya women complain about poor treatment by health personnel and/or of not being understood. Indigenous women cite language barriers as a primary problem. Forty per cent of Guatemala's indigenous population speaks one of 20 Mayan languages and many patients do not speak Spanish. The majority of state health workers do not speak or understand indigenous

Mayan languages.

This means some indigenous Maya women are often unable to adequately describe their symptoms or understand medical instructions from health staff. The researchers point out that this creates barriers and ill will between the indigenous community and the health centre, preventing other indigenous people from seeking clinical health care in the future.

According to the WHO, one notable complaint by indigenous patients is that most western-oriented services ignore the spiritual and mental side of physical ailments and general health care. Consequently indigenous Maya communities continue to use traditional ancestral medicines and health specialists to meet most of their health care needs.

Cultural disconnects

National Ministry of Public Health surveys have revealed that some symptoms attached to illnesses have no explanation within the concepts of conventional mainstream medicine. However, they are a functional part of the Mayan indigenous health system of *Ráaxk'aslemal* (fullness of life). This is characterized by a search for harmonization and balance and includes perceptions of life and death that may differ from western philosophical traditions.

Many indigenous women who have given birth in hospitals have complained about the poor institutional care they have received. This includes feeling abandoned. Women prefer giving birth at home where they have a higher chance of obtaining family and community psychosocial support.

Guatemalan traditional medicine

The principal traditional medicine specialists, such as bonesetters, herbalists and massage therapists, use a variety of medicinal plants, flowers, roots and tree barks, and also make use of animal fats, bones, skins and oils. As elsewhere in the Americas, traditional Mayan medicine is learned through apprenticeships, practice, observation, psychological readings and intuition. The collected knowledge and wisdom is transmitted orally across several generations usually within families.

Birth attendants are crucial. According to

the PAHO about 75 per cent of births in rural areas occur in the home, often in poor hygienic conditions with women preferring the services of traditional midwives (*comadronas*). Unlike purely clinical approaches, traditional birth attendants incorporate traditional beliefs and medicinal plants (e.g. sedative grasses) in their work. This preserves a connection with the natural and supernatural worlds and even the patient's own standing in the community.

This is one reason why indigenous Maya women in Guatemala – as in other indigenous communities of Latin America – tend to exhaust all traditional therapies before seeking conventional treatment. Nevertheless, some traditional midwives lack the training needed to deal with complicated pregnancies and their methods may risk endangering women's lives.

ECLAC data indicates that the Guatemala maternal mortality rate of 280 deaths per 100,000 live births (in 2010) is nearly 300 per cent higher than the regional norm of 81. Moreover, within indigenous communities, the PAHO estimates the rate to be even higher. In 2000, the main causes of maternal death were haemorrhage (53.3 per cent), infection (14.4 per cent) and hypertension (12.1 per cent).

There have been officially noted concerns over traditional midwife practices and their links to high levels of maternal mortality in rural areas. However, perhaps even more important is the very close link to poor nutrition and poor prenatal care. According to the PAHO, about 65 per cent of Guatemalan women do not have prenatal check-ups. The lack of medical care during pregnancy and birth has permanent health consequences for undernourished indigenous women including anaemia, and otherwise preventable genital and urinary infections. On the other hand, indigenous women also claim that health personnel treat both traditional birth attendants and their patients as inferiors, and often do not provide the *comadronas* with sufficient equipment or training. The sum total is that most cases seen by modern doctors are already in advanced stages of complication, often beyond prevention and frequently incurable.

Traditional medicine is recognized by Guatemala's Constitution as well as by the *Acuerdos de Paz* (Peace accords) that followed

the intensely violent (and arguably genocidal) 1978–85 civil war. It guaranteed compliance with the UN ILO Convention No. 169 on indigenous peoples' rights.⁷

Since 1996, the Ministry of Health has been training midwives in safe birthing techniques. Courses in traditional medicine are also available for non-indigenous health professionals through the Public Health Ministry.

Panama

According to the ECLAC, 68.7 per cent of Panama's population are urban dwellers. With a per capita GDP of US\$7,265 in 2011, of which 8.1 per cent was spent on health, Panama ranks among the most developed societies in Latin America.

However, Panama's wealth is concentrated in the main urban areas. The urban poverty rate in 2011 was 15.5 per cent with 4.7 per cent in extreme poverty. In contrast, the rural poverty figure was 43.6 per cent with 26.8 per cent in an extreme condition. The majority of Panama's indigenous people live in the under-served peripheral rural zones of the country.

Indigenous groups

The three main indigenous groups are Ngöbe-Buglé (sometimes called Guaymís), Kuna and Embera-Wounan (Darienitas or Chocós). Of these Ngöbe-Buglé account for almost two-thirds of the 200,000 indigenous population, with Kuna being the second largest group.

Half of all indigenous children suffer from malnutrition, while only 10 per cent of non-indigenous children are undernourished, according to the PAHO. Infant mortality among Panama's indigenous population is approximately 40 to 50 children for every 1,000 live births. In stark contrast the national average is 19, which is considered a very positive ratio for Latin American countries. The huge difference is another expression both of income concentration and the public policy towards the country's indigenous population.

Housing problems and lack of basic services such as potable water and sanitation promote diseases including diarrhoea, typhus and other health problems. These affect mostly indigenous children, and are directly connected to the social,

economic and political marginalization of the respective populations.

In addition, access to formal health services and institutions by the majority of the rural indigenous population in Panama is limited. This is partly due to the dispersed nature of the population and the distance between their communities and the nearest medical services. In some areas, indigenous people need to walk between three and five days to get to a health centre and there is no guarantee there will be personnel or medicines on hand. Language is also a significant factor. Many poor indigenous families are headed by monolingual non-Spanish-speaking parents who are also non-literate.

Health care initiative

In September 2011 Panama received a loan of about US\$50 million from the Inter-American Development Bank (IDB) to reorganize its primary health care system and improve maternal, neonatal and chronic disease care.

The loan is aimed at improving services in nutrition, reproductive health and dental care. It is intended to help reduce maternal and infant mortality rates as well as the prevalence of chronic malnutrition among children under the age of 5. It remains to be seen what effect this investment will eventually have in improving health conditions of rural indigenous communities.

Privatization moves

In an effort to raise revenue to repay international debts and stimulate development, during the past two decades Panama has been engaged in an aggressive programme of privatizations. In October 2012, the government put into effect a plan to sell off state-owned lands in the Free Trade Zone of Colón, which has a large Afro-Panamanian population.

Free Trade Zone businesses are a major source of employment in the otherwise depressed area, and during 2012 Colón residents picketed and street-marched for months to protest the planned sale. They argued that the land sale in the biggest duty-free zone in Latin America would cost jobs, cut incomes and deconstruct the largely Afro-Panamanian community.

The actual passage of the new law in October

led to a sharp escalation of marches, and street blockages. Security forces answered with tear gas, bird shot and rubber bullets. According to local media sources, three people were killed in the clashes.

Protesters argued that the land sale was an inadequate solution to raising additional revenue to pay for large national projects whose economic benefits largely bypass Colón's economically depressed and marginalized Afro-Panamanian and indigenous populations.

Among residents' complaints during the protest were that some Colón communities had not had access to water facilities for months, thereby raising the risk of gastrointestinal and other infections. Following the adverse international publicity and the protesters' refusal to enter a dialogue unless the new legislation was repealed, in October Panama's President Ricardo Martinelli said he would scrap the land sale plans. Instead, according to BBC News, commercial rents would be increased and the money reinvested in the area, as protesters had been demanding.

The protest and deaths in Colón were just one in a string of incidents across Panama during 2012 where police were accused of using excessive force to disperse demonstrations over social and economic policies that have a potentially negative effect on the health and well-being of minority and indigenous communities.

Over the past year and a half, indigenous Ngöbe-Buglé have also relentlessly fought for their right to free, prior and informed consent concerning the growing number of mining and hydroelectric projects on their lands. They too have been met with serious force from the police.

Opposition to governments plans first prompted blockades of the Pan-American Highway during February 2012. These cost several lives, but forced an agreement that prohibited mining and hydroelectric power projects in their territory (*comarca*) located on the north-west coast, bordering Costa Rica.

However – in what critics see as a familiar pattern – the government backtracked and in February 2012 the Ngöbe-Buglé community resumed their protests to again force the government to negotiate. Two people were killed by security forces, dozens injured and

many detained.

Finally, in March 2012, elected Ngöbe-Buglé leaders and Panama government officials reached a new agreement. All mining was banned in Ngöbe-Buglé territory. The agreement also requires community consent for any hydroelectric projects via referendum vote.

Nevertheless, a dissenting group of Ngöbe-Buglé resumed street protests in opposition to the agreement, particularly regarding permits for hydroelectric projects. According to AFP wire service, the Ngöbe-Buglé General Congress, which represents the traditional indigenous leadership, does not recognize indigenous leaders formally elected under government rules. Ngöbe-Buglé traditionalists continue to reject all hydroelectric projects in their territory for economic and cultural as well as health reasons.

They argue that the Barro Blanco hydroelectric dam, when completed, will flood Ngöbe communities along the Tabasara River. Places at risk include schools, cemeteries, cultural sites and rich fertile farmlands. They also cite health risks. The president of the Indigenous M-10 (Movimiento 10 de Abril) protest movement especially argues the project will change the currently fast-flowing fish-filled Tabasara River into an expanse of still water ideal for breeding disease-carrying mosquitoes in a country long noted for a high incidence of malaria and yellow fever and in an area with inadequate health services.

According to a UN report, some of the sites to be flooded are of significant cultural and religious value. This includes ancient boulders carved with petroglyphs that were the key to recreating the Buglé written language, and led to a revival of indigenous culture in the area. Indigenous activists across the Americas argue that such religious and cultural disruptions, which have now continued for several generations, are among the main contributors to the ongoing mental health issues that continue to affect aboriginal communities from Alaska to Argentina.

Peru

Despite steady economic growth during recent years, health investment in Peru remains among the lowest in Latin America. According to the ECLAC, Peru had a per capita GDP of

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Case study
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Honduras: first Garifuna community hospital offers alternative model for community- based health care delivery

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The approximately 700,000 African-descendant Garifuna community in Honduras represents nearly 10 per cent of the country's total population.

According to ECLAC, the per capita GDP in Honduras was US\$1,519 in 2011. Consequently, the 6.8 per cent of GDP the state allocated for health care was not likely to go very far. The limited expenditure meant that during 2012 Garifuna medical professionals needed to continue their efforts to develop and finance their own community-based health care delivery system.

Their initiative has links with the devastating Hurricane Mitch of 1999 which destroyed more than 50 per cent of Honduran infrastructure; the predominantly rural indigenous Miskito and Garifuna communities were completely cut off. Nevertheless, this ill wind ended up blowing some good in the form of a revolutionary change in Garifuna health care options.

The disaster produced an immediate response from the international community. This included a medical contingent from Cuba that reached some of the most remote and hardest hit Garifuna villages. Besides providing urgent immediate help,

according to Garifuna community health care pioneer Dr Luther Castillo, it opened the way for some young Garifuna to also become health professionals. Given the low per capita income and a national history of ethno-racial discrimination a career in medicine had always seemed too remote a possibility.

Although founded in 1847, the School of Medicine of the National Autonomous University of Honduras (Universidad Nacional Autónoma de Honduras, UNAH) did not graduate the first Garifuna doctor until 1962. Since then, high costs, social marginalization and the difficulty in gaining admission had ensured that the dream of pursuing a medical career would continue to elude the majority of Garifuna high school graduates.

Latin American School of Medicine

The chance for change came with the 1998 establishment in Cuba of the Latin American School of Medicine (Escuela Latinoamericana de Medicina, ELAM). ELAM then also initiated a scholarship programme to train several thousand doctors from Latin America, Africa and Asia. As a result, by 2012 11 Garifuna medical students had become doctors. This is more than had ever graduated in the entire 115-year history of the UNAH, and new classes were being trained at the ELAM during 2012.

Student work brigades

Among the earliest graduates was Garifuna community health pioneer Dr Luther Castillo, who was in the very first ELAM graduating class in 2005.

While still in medical school, Garifuna students began looking for ways to immediately start contributing to community health improvement. The result was the creation of Garifuna Medical Student Work Brigades. All Garifuna students since then donate 15 days of their annual vacation from medical school to work alongside the Cuban and Garifuna doctors in various Garifuna communities.

From 2001 onwards, the student work brigades have helped run the permanent clinics established in at least 12 of the 46 widely separated Garifuna communities along the Honduran coast.

Case study continued

In 2005, three Garifuna doctors set out to build the first clinics for communities that had no prior access to health care. They also worked to develop a comprehensive system of preventive health care and patient education that focused on Garifuna community cultural realities. They organized a broadly based community volunteer structure to assist with all aspects of fund-raising, construction, service development and sustainability.

As the first phase, they decided to develop a free community hospital. They established a camp at the proposed site and began treating the first patients even though construction was still under way. It helped to generate interest and hope.

They also created alliances between faith groups, women's organizations, students and workers. The organizers used online social networks to link their efforts with similar health care delivery models. This included international research institutions, universities, international medical volunteer teams, health care NGOs and social movements.

According to the organizers, acquiring the support of Garifuna women was crucial. In addition to spearheading the mobilization process, they worked alongside community carpenters and bricklayers in getting the building finished and played a key role in the overall success of the project.

Following a substantial effort at fund-raising and community mobilization, the group of young doctors headed by Dr Luther Castillo gradually completed the first Garifuna hospital in Honduras.

The hospital is located in the community of Ciriboya, Colón, in the north-east of the country. It is a very remote marginalized area with few roads – all unpaved – no electrical connections and no government health services. Patients need to walk for many miles along the beach with the sick suspended in hammocks in order to receive any medical attention.

This is also an area where both Garifuna and other indigenous peoples continue to lose their ancestral lands and ocean fishing rights to land

grabbers and international corporations that have established extensive palm oil plantations in the Baja Aguan region. According to MRG partner in Honduras OFRANEH (National Fraternal Organization of Black Hondurans), armed paramilitaries are used to crush indigenous community protests, and there are also instances of verbal harassment by the rifle-toting company 'guards'. The latter park on public access roads and are prone to showing displeasure at the presence of the young 'rights-defending' Garifuna doctors and nurses in the area.

First Garifuna hospital

The modest two-floor hospital was inaugurated in 2007 by the left-leaning President Manuel Zelaya – who was subsequently unseated in June 2009. By 2012, there were well-equipped rooms for delivery, a pharmacy, ultrasound department, a small laboratory and a dental room. Electrical power was supplied by solar panels.

The hospital directly serves the more than 30,000 residents in the Ciriboya zone and, if the surrounding area is included, regularly reaches a total of 60,000. According to the staff, who essentially work as volunteers, the hospital has provided almost half a million free consultations since 2007.

In addition, using the free hospital and clinics as a base, the far-ranging bilingual Garifuna health team and brigades provide medical consultations and medicine without cost to the more than 500,000 Garifuna living in the isolated Garifuna communities on Honduras' Caribbean coast.

Organizers claim that to date over 240,000 free medical treatments have been administered. Based on local rates, this totals about 144 million Honduran Lempiras (US\$7.2 million). It is money that the Afro-Honduran population – marginalized and discriminated against – did not have to find in order to take care of their own health needs.

Comprehensive care strategy

Part of the health strategy also involves encouraging community projects that aid mental and physical well-being. Health system founder Dr Luther Castillo describes it as 'inter-culturally

oriented medicine'. It takes a broad-based inclusive approach.

While using modern medicines, it matches the cultural modes, practices and material needs of the community and its traditions.

This means that a female patient with back pain from carrying heavy bundles of fuel wood will be treated for the physical ailment, and also the underlying causes. In addition to prescribing rest and medication, efforts will be made to provide the patient with a community-built solar stove to reduce firewood needs.

The health teams have been able to provide health education to more than 200,000 youth. They have also organized interventions in schools on topics ranging from intestinal parasites to alcoholism, sexually transmitted diseases to self-esteem. This includes setting up health-promoting soccer fields and volleyball courts.

International solidarity

Since the hospital and the community health system receive no support from the Honduran government, the support they get from voluntary service networks at the national and international level is very important, say the organizers.

The hospital receives help from an average of 30 international medical brigades that visit the community annually from North America. Almost all of the material used in the medical work comes from donations and fund-raising,

including within North American migrant Garifuna communities.

Assistance also comes in conducting scientific studies in conjunction with US-based academic and other institutions. They conduct medical research on chronic illnesses that particularly affect Garifuna communities. These include diabetes, high blood pressure, kidney failure, sickle cell anaemia and venomous snake bites.

In addition to providing patient care, the hospital also runs a two-year nurses' training programme for local women and works with international NGOs to help train Garifuna women to be midwives.

Given the training costs and other aspects of hospital and system maintenance, the organizers need to expend substantial time and effort in local and international fund-raising.

Unhealthy relations

While efforts at international linkage and fund-raising have borne fruit, the Garifuna health system organizers have been much less successful in getting the model incorporated into the official Honduras health structure.

In November 2008, a commission for the improvement of the health sector (Proyecto de

Below: Garifuna doctor consults visiting patients at a community health clinic, Honduras. *Garifuna Hospital Photo Archives.*



Case study continued

Reforma del Sector Salud, PRSS) examined the hospital in relationship to the state.

An agreement was signed in April 2009 between the Department of Health and the Association of Honduran Garifuna Municipalities (MAMUGAH). It was due to be renewed in July of that year making the hospital an official part of the Honduran Department of Health. Then a coup happened.

Following the June 2009 presidential ouster, the new administration proposed a significantly modified new agreement. The original model had focused strongly on preventive health care and direct Garifuna community involvement in management and control using the Garifuna native language. It favoured the training and employment of local community health workers. It took into account modern medical practices, as well as socio-economic and geographical conditions, and indigenous Garifuna preventive care, healing methods and medicines. It was all based on the free, prior and informed consent principle.

After the coup, the Department of Health proposed changes that centralized all aspects, including staff appointments. This meant that an agreement could not be reached, and the Garifuna health system has remained outside of the national framework.

According to the programme's director Dr Luther Castillo, health investment in Honduras is already low, plus people of African descent feel they are still treated as 'folkloric objects', and exposed to racist ridicule, belittling media images and xenophobia. Therefore, Garifuna communities consider it important to maintain control of their health delivery process.

'We were expecting official recognition and respect for our cost-effective community-based system, but the Department of Health was unwilling to change the long-held attitudes to our communities. So we just have to find ways to keep going and expanding the services on our own,' Castillo said. ■

US\$5,378.50 in 2010, but spent just 5.1 per cent of that on health. This lack of investment is especially felt in the poorer areas, where indigenous and Afro-Peruvian populations are predominant. These include the marginalized urban *colonias* around Lima and the rural communities along the Pacific coast, in the Andes mountains and in the Amazon rainforest. In these rural zones the ECLAC indicates that 56 per cent of the population is classified as poor, versus 18 per cent in urban areas.

Biases in services

According to MRG partner CEDET (Centro de Desarrollo Étnico), a study carried out by Peruvian human rights organizations in 2005 revealed that the government spends more than twice as much per person in service delivery to the more prosperous regions than in the poorer departments. The ECLAC data indicates that, in 2010, some 84.6 per cent of urban households had sewerage services versus 44 per cent in rural areas. Also in urban areas, 88.8 per cent had piped water compared to 38.4 per cent of rural homes, and electricity reached 92.1 per cent of urban homes but just 28.2 per cent in rural zones.

Inequality in health service access is reflected in the contrast between the maternal and infant mortality rates of the richer urban areas, compared to those with majority indigenous and Afro-Peruvian populations. According to the ECLAC, the maternal mortality rate in Peru during 2010 was 67 per 100,000 live births with infant mortality being 18 per 1,000 live births. Although these represent a considerable improvement compared to previous years, the positive change has mostly been limited to urban groups with higher incomes. According to CEDET, the rates of infant and child mortality continue to be especially high in indigenous and Afro-Peruvian communities where CEDET research indicates that 92 per cent of African descendants live below the poverty threshold.

Critics argue that in general there is a lack of a clear policy, appropriate financing and adequate service delivery to these populations, especially given their culturally specific health needs. The official focus is curative more than preventive, with an emphasis on reproductive health that

ignores the non-reproductive and preventable illnesses that also affect women, including hypertension and diabetes.

CEDET further argues that adding to the economic challenges that impede access to proper health services for indigenous and Afro-Peruvian communities are the racism and discrimination connected to their cultural and ethnic identity. The perception of many indigenous women is that they are treated with contempt bordering on abuse in some health centres because they are poor and also come from indigenous communities. They complain that among the factors affecting treatment quality are that both rural and urban health staff do not bear in mind their beliefs and cultural practices.

For example, indigenous women in Andean communities have traditionally held that the best orientation for delivering babies is in the vertical position, or kneeling down, which they feel aids the functioning of abdominal muscles. Nonetheless, CEDET points out that the vertical childbirthing of indigenous Andean women is routinely viewed with scepticism – and even ridiculed – by local health professionals, all of whom have been trained to follow western medical modalities.

As in other countries in the Americas, the situation is complicated by language. In Peru health professionals very rarely speak the languages of the indigenous communities they serve. Therefore, it is often impossible to explain the prescribed treatment or to obtain informed consent. This in turn promotes more anxiety and mistrust.

Traditional cures

For these reasons indigenous women prefer to use traditional medicine and to give birth at home. According to the PAHO almost 50 per cent of deliveries in Peru are conducted at home, mostly by traditional midwives or by family members. Of these some 83 per cent occur in rural areas. The PAHO studies also indicate indigenous women particularly prefer traditional midwives because they feel understood and respected by them.

According to CEDET, this indigenous cultural preference can produce added bureaucratic challenges. Some health centre personnel refuse

to provide live-birth verification to indigenous babies born at home or whose parents have not been able to pay a punitive fine for not submitting to official prenatal control. Without this document, the child cannot receive the official birth certificate, which is needed to obtain national identity documents.

Peruvians without identity documents are deprived of a range of rights, among them – ironically – the right to join the national health insurance programme (introduced in 2002), which is mandated to provide free attention to all Peruvians who cannot afford to pay.

In recent years according to the PAHO, progressive medical trainers in Peru have been stressing the importance of cultural awareness, and paying more attention to the positive aspects of traditional medicine such as the extensive accumulated knowledge of herbal treatments.

United States of America

US elections

During early November 2012, the first African American president in US history, Barack Obama, was re-elected to a second four-year term in office. The Democratic president convincingly triumphed in the number of states required for victory; however the popular vote was split roughly in half, with the win reflecting a slim 2 per cent margin.

The re-elected administration will also have to face a House of Representatives that remains under the control of the Republicans who oppose many of the policies endorsed by minority and indigenous Native American voters.

Analysts attributed the result partly to changing US demographics, with the Republican opponent Mitt Romney failing to convince a sufficient number of minorities, women and youth voters that he would do better than the Obama campaign promised in areas such as the economy, immigration reform and health care coverage. According to exit poll analysis by the Pew Research Center, non-white voters now make up 28 per cent of the nation's electorate, compared to 26 per cent in the 2008 election.

Latinos (or Hispanics) are the fastest-growing demographic in the country and the US Census Bureau estimates that Latinos will comprise one-third of the US population by 2050. Already



in California and Texas nearly 40 per cent of the population is Latino. According to exit poll analysis, Latinos voted for President Barack Obama over Republican Mitt Romney by 71 per cent to 27 per cent.

In addition, national media reported that Obama received almost 96 per cent of all African American votes. While over the past two decades some educated African Americans have achieved better income levels, a disproportionate number still remain on the lower rungs of the US socio-economic ladder.

African Americans

According to the Economic Policy Institute, African Americans are as residentially isolated from Euro-Americans as they were in 1950, and more isolated than in 1940. A significant number nationwide remain concentrated in marginalized, distressed low-income urban neighbourhoods

with insufficient social investment, including inadequate housing, rent and mortgage challenges, and constrained educational opportunities.

Unemployment levels are high and sustained employment is infrequent and mostly low wage. The US Census Bureau's Surveys of Income and Program Participation (SIPP) indicate that hardship conditions such as food insecurity and unmet health needs were virtually the same for poor able-bodied African American families with children, regardless of whether most of their income derived from employment (48 per cent) or not (47 per cent).

These under-serviced urban communities also have a high ratio of under-educated school drop-outs, alienated youth and youth-related gun violence, resulting in a significant risk of firearm injuries and homicides. According to the US Centers for Disease Control and Prevention,

Left: Native American Chugach man hangs smoked salmon in Alaska. *Catherine Karnowl/Corbis Images.*

homicide is the leading cause of death for the majority of young African Americans between the ages of 10 and 24 years old.

African American children in low-income urban families frequently suffer from health problems that lead to school absences and educational disruptions. The ongoing individual and environmental stress affect personal as well as collective well-being, promoting further social and cultural disintegration, self-destructive behaviour and a range of other mental health problems.

Immigrant minorities

As with other US minorities, factors such as unemployment, youth violence, inadequate education, and economic and health care challenges also negatively affect Latino communities.

Latinos are disproportionately affected by poverty, food insecurity and unemployment. Homicide is the second-leading cause of death among young Latinos between the ages of 10 and 24 years old, according to the US Centers for Disease Control and Prevention.

The Census Bureau's SIPP indicated that nearly 31 per cent of Latino citizen families with children experienced overcrowded housing, food insecurity or unmet medical needs. For non-citizen Latino families it was 47 per cent. According to the NGO Feeding America, more than 25 per cent of Latino households are considered 'food insecure' and are disproportionately represented among those receiving emergency food aid.

However for Latino voters, besides these factors, of major community concern was the need for immigration reform, especially in light of undocumented immigrant profiling policies and the banning of ethno-cultural studies in some states such as Arizona.

Undocumented immigrants

The US government estimates that there are 11 million undocumented immigrants in the US. According to the Pew Hispanic Center, 56 per

cent are from Mexico and 22 per cent from other Latin American countries, primarily Central America and the Caribbean. In a nation with sharply divided views on the subject, the Obama administration was unable to implement any immigration reforms during its first term.

During the 2012 election campaign, most Republican candidates continued to call for tough immigration measures. By year's end, the US Congress had been unable to agree on an amnesty programme for undocumented immigrants. According to US Immigration and Customs Enforcement, nearly 397,000 undocumented aliens were deported in 2011, returning to already economically challenged Latin American countries.

Despite the Congressional gridlock, polls by Pew Research also indicated that among all US voters, 65 per cent think immigrants should be offered a chance to apply for legal status.

Native Americans and indigenous Alaskans

In December 2012, hundreds of tribal leaders attended the fourth White House Tribal Nations Conference at the US Department of the Interior. During the encounter tribal leaders had the opportunity to discuss and highlight issues such as self-determination, culture, and the economic challenges faced by their communities.

In addition to specific historically related Native American concerns such as land loss, resource control and prior and informed consent, there are other emerging issues. These include pollution of the Arctic, which is home to Alaska's indigenous populations. This region continued to have the highest levels of 'persistent organic pollutants' (POPs) on earth.

POPs are artificially created organic compounds that resist natural breakdown and can persist for many years. These highly tenacious and toxic health-threatening substances are transported for thousands of kilometres by rivers, and by ocean and air currents from warmer parts of the globe to the colder polar regions. They accumulate in the fatty tissue of seals and whales that traditionally play a key role in the Arctic indigenous diet and can be passed directly to infants through maternal breast milk, causing disruption of the hormone and immune systems, and affecting postnatal growth.

Like other minorities in the US therefore – and perhaps to an even greater extent – Native Americans and indigenous Alaskans continue to face many challenges in the areas of housing, education, employment and especially health. Not least among these is the issue of mental health.

Native American youth suicide emergency

During 2012, Native American leaders and activists continued to be greatly alarmed at what they describe as a youth suicide epidemic sweeping US Native American communities. According to reports by the US Surgeon General, suicides among young Native Americans between the ages of 15 and 24 are 3.5 times higher than the national average and rising. Moreover, 40 per cent of Native American suicides occur within this age group.

Suicide figures vary by community with the most troubling numbers being in the Northern Plains, parts of the south-west and Alaska. According to the Alaska Native Tribal Health Consortium, the suicide rate for young Native Alaskan males (Inuits) is about nine times that of all young males in the country. The White Mountain Apache Tribe has mandated the reporting of all suicides and attempted suicides on their Arizona reservation, and discovered that between 2001 and 2006, Apache youth ended their lives at 13 times the national rate.

Although Native American communities have experience of suicide, according to *fronterasdesk.org*, a media organization in the south-west, it is culturally regarded as taboo on some reservations, so there is no native language word for 'suicide'. Consequently, suicides often go unreported or get classified by police as accidents. Given the growing crisis some tribes have now declared states of emergency and set up crisis-intervention teams.

Historical trauma

Activists argue that one of the principal factors driving the high suicide rates in Native American communities is what they call a collective community-wide historical trauma that has a strong connection to cultural breakdown. Researchers in 2011 reported that – even more often than Native American adults – as many as 20 per cent of Native American adolescents thought daily about issues stemming from native

land dispossession, marginalization, language loss, cultural disintegration, exclusion and more.

On some reservations, Native American unemployment is over 80 per cent. There are few full- or even part-time jobs available in a national economy constrained by the severe economic slowdown. Many Native Americans live below the federal poverty line.

Among the socio-economic factors driving the high suicide rates therefore are extreme poverty, hunger, alcoholism, domestic violence (physical and psychological) and substance abuse.

In addition, Native American women experience high rates of rape, as well as unintended and teenage pregnancies. Victims complain that attempts to obtain justice are sometimes met with prejudicial and even violent treatment by law enforcement and other public officials, or trivialization and a lack of understanding of their situations.

US indigenous communities face a range of other health challenges which also contribute to the overall problem. According to the US Department of Health and Human Services these include higher than average mortality rates from tuberculosis, chronic liver disease and cirrhosis, and motor-vehicle accidents compared to other minority communities. Asthma rates in some areas are twice the national average.

The diabetes rate among Native Americans is at an all-time high and often remains untreated. At 16.5 per cent, it is higher in the indigenous population than in any other major US ethnic group.

All such issues end up weighing heavily on the minds of native youngsters, which, activists argue, produces feelings of hopelessness. Mental illness such as depression is therefore common.

Behind trans-generational alcoholism and depression, there are also long-lasting memories in some families of sexual abuse by religious clergy. Lawsuits have detailed a history of sexual, physical and emotional abuse by parish priests as well as by staff at traumatizing, culture-erasing, faith-based boarding schools that Native American children were forced to attend until the 1970s.

Seeking solutions in indigenous culture

There is a consensus among both Native American and non-Native health professionals

that tradition and cultural healing are key elements in countering the deeply embedded suicide risk factors.

According to Indian Country Today Media Network (ICTM), studies by US and Canadian researchers conclude that traditional ties and cultural connectedness provide important psychological and practical physical benefits and antidotes. Family and clan relationships, reverence for elders and a deeply held spiritual life are among the key protective factors. Supporting these culturally based positives makes Native youth feel valued and able to seek help.

Financial support

A number of US federal agencies and foundations provide grants and services to programmes that try to address the suicide problem. However, many programmes struggle to continue in a time of shrinking budgets.

During 2012, the US Indian Health Service (IHS), which serves the 566 federally recognized tribes, included 10 more tribes or tribal organizations in a batch of youth suicide prevention grants. That brings to 43 the number of indigenous groups that have received this form of IHS funding. Most will receive nearly US\$ 500,000 annually for three years.

However, leaders, such as former North Dakota Senator Byron Dorgan, who chaired the Senate Committee on Indian Affairs for four years, argue that, given the extent of the emergency, the IHS is inadequately funded to provide the needed level of mental health services.

According to the Pan-American Regional Office of the World Health Organization, only indigenous peoples living on or near their US reservations are eligible to receive IHS clinic and hospital care. It is estimated that only one-third of Native Americans live permanently on or near reservations. Another third reside in urban areas. The remaining third moves back and forth between the two.

Given that only 2 per cent of IHS funding serves urban communities, this means that at least half of Native Americans are not reached by IHS programmes.

Proposed legislation to prevent Native American suicides

In April 2012, Democratic Representative Joe Baca of California introduced a Congressional bill entitled the Native American Suicide Prevention Act of 2012. It requires states or state-sponsored organizations to consult with federally recognized Native American tribes and their organizations as well as urban Native American organizations in the development and implementation of state-wide suicide early intervention and prevention strategies.

However, the bill died in Congress from lack of support.

An indigenous NGO, Native Cry Outreach Alliance, which provides services in the area of youth suicide prevention and depression, took up the challenge of trying to obtain new Congressional support for the bill. This included seeking a Representative to commit towards reintroducing the bill to the newly elected 113th Congress during the 2013 sessions. At the end of the year, indications were positive that this would occur. ■

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RUSSIA

KAZAKHSTAN

UZBEKISTAN

TURKMENISTAN

KYRGYZSTAN

TAJIKISTAN

AFGHANISTAN

Jammu and Kashmir

PAKISTAN

TIBET

NEPAL

BHUTAN

BANGLADESH

BURMA

LAOS

THAILAND

VIETNAM

CAMBODIA

MALAYSIA

SINGAPORE

Borneo

BRUNEI

Sumatra

INDONESIA

Java

TIMOR-LESTE

PAPUA NEW GUINEA

Bougainville

SOLOMON ISLANDS

Wallis and Futuna (FR.)

FIJI ISLANDS

New Caledonia (FR.)

French Polynesia (FR.)

AUSTRALIA

NEW ZEALAND

PACIFIC OCEAN

INDIAN OCEAN

Asia and Oceania

Jack Dentith, Emily Hong, Irwin Loy,
Farah Mihlar, Daniel Openshaw,
Jacqui Zalcborg

Central Asia

Daniel Openshaw

Minority groups live in some of the poorest regions of Central Asia; Pamiris in Gorno-Badakhshan Autonomous Province in Tajikistan; Uzbeks in South Kazakhstan province; Karakalpaks in Uzbekistan's Karakalpakstan region; and high numbers of Uzbeks and Tajiks in Kyrgyzstan's Ferghana Valley. Poverty has a direct impact on their health. The right to free health care is enshrined in the constitutions of four of the five Central Asia states; Turkmenistan abolished free health care in 2004. However, the reality is not as straightforward as reports are commonplace of bribes being necessary to gain access to health care.

Official health data – disaggregated by either ethnicity or gender – is not widely available in the region, but some information is available from international organizations. For example, a 2008 World Health Organization (WHO) report found that inequity of access to mental health services was an issue for minorities in Kyrgyzstan that should be addressed.

The rate of new HIV infections continues to rise across Central Asia according to UNAIDS; in Kyrgyzstan and Kazakhstan new infections rose by 25 per cent between 2001 and 2011. Drug resistant tuberculosis and malaria also disproportionately affect people living in poverty or social exclusion, including minorities, according to the United Nations Development Programme (UNDP).

Prisoners are another population at risk of contracting HIV and tuberculosis, or suffering from mental health problems and other problems associated with drug use. This particularly affects minorities, given the high numbers of ethnic and religious minorities among prison populations in Kyrgyzstan, Uzbekistan and Kazakhstan.

Climate change is exacerbating the effects of long-term mismanagement of water resources,

Right: Uighurs in Kazakhstan picking fruit from a tree. *Carolyn Drake/Panos.*

which affects the health of the most vulnerable people living in the region. In March, the Asian Development Bank (ADB) reported that the shrinking of the Aral Sea and drying up of two major rivers, the Amu Darya and Syr Darya, would particularly affect Karakalpakstan – an autonomous region of Uzbekistan, home to the majority of the country's Karakalpak population, as highlighted in MRG's 2012 *State of the World's Minorities and Indigenous Peoples*.

In an already poor region, climate change is especially significantly affecting the most vulnerable. Most people in Karakalpakstan depend on agriculture, so water shortages have reduced farmers' income and resulted in food shortages and poor health through malnutrition. Overuse of pesticides has also polluted water supplies and caused health problems, such as kidney and liver disease, tuberculosis and cancer. Many people want to migrate due to poor environmental conditions.

Climate change and mismanagement of water resources have also led to water shortages in southern Kyrgyzstan, home to many minorities, particularly Uzbeks, according to a 2012 report by the ADB. The ADB report highlights other environmental problems in the region: glacier melt in Tajikistan – the poorest country in the region – which will reduce access to water, and desertification in Kazakhstan.

Kazakhstan

Incumbent president Nursultan Nazarbaev and his Nur Otan party won parliamentary elections in January with 80 per cent of the vote. The Organization for Security and Cooperation in Europe (OSCE) criticized the elections for failing to meet democratic standards yet again. Two other political parties considered loyal to Nazarbaev also gained seats in parliament. Women continue to be under-represented in government, with 27 of 77 seats in the lower house of parliament and 2 of 47 in the upper house.

There are still very few ethnic minority representatives in senior government, which could in part be because of language barriers.



Although knowledge of Kazakh is not required for government and civil service positions – except for presidential candidates – non-Kazakh speakers complain that Kazakh speakers are favoured for government positions.

Nazarbaev's victory is seen to reflect a growing Kazakh nationalism in the country. Under his leadership, the creation of Kazakh-language schools and the conversion of some Russian-language schools to Kazakh reduced the overall number of Russian-only language schools. In March, Nazarbaev called for fewer home-grown films to be made in non-Kazakh languages and to show the country in a more positive light.

At the most elite end of public health promotion, home-grown nationalism was less of an issue for the government as naturalized or so-called 'plastic' Kazakhs made up over half of Kazakhstan's delegation to the London 2012 Olympics. The athletes included several Russians and three Chinese-born weightlifters, who took Kazakh nationality and changed their names to

sound more Kazakh. While offering substantial positive rewards and glory for successful competitors, this practice reportedly led to resentment towards 'plastic' Kazakhs, which could contribute to discrimination.

The situation for religious minorities deteriorated in 2012, following the adoption of a new Religion Law in late 2011. The law compels public organizations and religious groups to register with the Ministry of Justice and regional authorities, and has been enforced through fines and imprisonment. For example, in East Kazakhstan members of an unregistered Baptist group were fined almost 18 months' wages each.

Registration processes have been described as complex, arbitrary and expensive. The 2013 United States Commission on International Religious Freedom (USCIRF) report documented cases of corruption involving the re-registration process.

During 2012, numerous groups were not allowed to re-register. For example, members

of the Grace Protestant Church in Karaturyk, with a mainly Kazakh and Uighur membership, were pressured to remove their names from registration documents to prevent the church from registering. Some congregations of the Russian Orthodox Church Abroad were also affected. The government raided numerous places of worship and confiscated religious material, affecting Pentecostal Christian, Methodist, Hare Krishna and Jehovah's Witness groups.

Muslim groups have also been affected. Only groups that are part of the state-backed Sunni Muslim Board can register and in November some independent mosques belonging to Shi'a and Ahmadi Muslim communities were refused legal status. As a result the Ahmadiyya community in Almaty has nowhere to legally worship. Other mosques have also been threatened with demolition if their communities don't register with the authorities.

Human rights activists report that prison administrators do not allow prisoners to practise their religion. If members of unregistered groups were incarcerated they would face a prison system that has been criticized for providing insufficient access to medical care and having inadequate numbers of medical personnel, including infectious disease doctors, not monitoring antiretroviral treatment of HIV-infected prisoners, having shortages in medication, and having inadequate heating and ventilation systems.

In September, Uzbek Pentecostal pastor, Makset Djabbarbergenov, was arrested in Kazakhstan at the request of the Uzbek government for conducting religious activity. He was not extradited, partly due to international pressure, but he was held in detention for three months. Upon his release in December, Djabbarbergenov and his family left the region; he is banned from returning to Kazakhstan before 2017. Djabbarbergenov had previously been recognized as a refugee by the UN refugee agency, UNHCR.

The plight of Kyrgyz migrant workers also made the news in 2012 when three Kyrgyz who had suffered de facto slavery in Kazakhstan for about a decade were found and released in Almaty. Rights groups say that migrant workers' rights are often violated due to their lack of

legal documents.

Increasing numbers of Kyrgyz women are moving to Kazakhstan in search of work where they are vulnerable to exploitation. There were reports in 2012 that some migrant Kyrgyz women face mistreatment and exploitation. Poor female migrants are vulnerable to becoming forced sex workers, drug mules or victims of human trafficking to other countries, especially Russia. Their situation risks being compounded by medical problems, lack of access to proper health care and unwanted pregnancies caused by rape or forced prostitution.

This trend sparked debate in Kyrgyzstan in April when a female member of parliament proposed that women under the age of 23 should be banned from leaving the country for work in order to protect them from mental and physical abuse. However, this proposition is an inappropriate attempt to control women's freedom of movement.

Kyrgyzstan

Ethnic minorities are under-represented in the Kyrgyz government; non-Kyrgyz citizens constitute 35 per cent of the population but only 12 per cent of members of parliament. Women are also under-represented. Non-Kyrgyz speakers complain of a glass ceiling within the civil service, even though the law provides for the preservation and free development of minority languages alongside Kyrgyz as the state language and Russian as an official language.

More positively, in December 2012 President Almazbek Atambaev refused to sign a bill that would introduce fines for public officials who do not have sufficient knowledge of Kyrgyz language.

In January Kamchybek Tashiev, leader of the nationalistic Ata-Jurt party, which holds seats in parliament, called for the then prime minister, Ormunbek Babanov, to resign because his mother was not from Kyrgyzstan. Tashiev said: 'I should say openly, and let people not be offended, that the head of government should be a pure-blooded Kyrgyz, who will actually be rooting for the interests of the country.' The statement sparked debate and media attention, as well as reportedly an investigation by the State Security Service.

Ata-Jurt also supported nationalistic protests

in Osh in the run-up to council elections. The poll led to a strengthened position for nationalist mayor Melisbek Myrzakmatov, with his supporters almost achieving a majority in the city council. This is a sign of growing Kyrgyz nationalism in the city. The election results prompted the International Crisis Group (ICG) to warn that Uzbeks are being pushed to breaking point by the discrimination and anger directed towards them, and that Myrzakmatov is largely to blame for this. Too little has been done in the way of inter-ethnic reconciliation, according to ICG.

June 2012 marked the second anniversary of the ethnic clashes between Uzbeks and Kyrgyz in Osh and the neighbouring region of Jalalabad, in which more than 400 people were killed and thousands more displaced. In the run-up to the anniversary, authorities tightened security and carried out passport checks expecting trouble. A National Remembrance Day – 10 June – was instituted and marked by the opening of the country's biggest mosque in Osh city in a bid to instil some unity. However, a bell dedicated to those who lost their lives during the violence was also unveiled in Osh in the summer with 'Peace all over the world' written in Kyrgyz, Russian and English – but not Uzbek.

Ethnic tensions remain high. In June an Uzbek rap song about regional leaders in Osh province offensive to Kyrgyz people started circulating online, where the song had been said to spark several minor ethnicity-based incidents and was promptly banned by the provincial court for inciting ethnic hatred.

The US State Department 2012 human rights report states that trials of ethnic Uzbeks for crimes committed during the 2010 violence continue, with some cases of previously lenient sentences being overturned in favour of harsh ones. Human Rights Watch questioned the fairness of trials for non-Kyrgyz citizens after one ethnic Uzbek and one ethnic Russian were sentenced to death in October for crimes committed during the inter-ethnic violence.

In April 2013, the UN Committee on Elimination of Racial Discrimination reported that Uzbeks were the main victims of the June 2010 events but were also the most prosecuted and condemned. The committee recommended that the government investigate the courts'

'biased attitude' and that it review their guilty verdicts. However, Uzbeks continue to report police harassment, and continue to be disproportionately prosecuted and incarcerated.

Throughout 2012 crowds of courtroom spectators, including family members of victims, disrupted trials of ethnic Uzbeks charged with crimes related to the 2010 violence, threatening the security and the safety of defendants, attorneys and judges.

The strength of inter-ethnic feeling can be seen in an incident in September; Kyrgyz residents in Ala-Buka, Jalalabad (another site of violence in 2010), beat up a judge following the exoneration of a local ethnic Uzbek who was found not guilty of assaulting a local Kyrgyz citizen.

In prisons, a disproportionate number of ethnic minority prisoners serve life sentences and so face numerous health risks, including high levels of drug use. UN Special Rapporteur on torture Juan Mendez noted poor prison conditions, including the use of torture, on his visit to the country in December 2011. In January 2012, prisoners organized a nationwide hunger strike by sewing their mouths shut in protest against poor conditions. The protests, led by an ethnic Uzbek, also aimed to highlight the corruption and criminality rife in the prison system.

Ethnic Uzbek citizens in Osh and Jalalabad face discrimination when looking for work, particularly within public services, according to the 2012 US State Department report on human rights in the country. There have also been multiple reports of seizure of ethnic Uzbek businesses and property.

As 2015 approaches, assessment of how countries have lived up to the Millennium Development Goals has begun. In 2012, research published in *The Lancet* medical journal showed that Kyrgyzstan and Uzbekistan were the two most equitable countries out of 54 studied in terms of mother and child health interventions. This is not to say that interventions were necessarily good, but that access was not determined according to wealth.¹

In terms of HIV, 70 new cases in children – 10 in Jalalabad and 60 in Osh, both with large Uzbek populations – were announced in June 2013 and attributed to accidental transmissions in regional hospitals. This follows an incident in 2010 when

a large number of women in Osh were infected with HIV. Even though it was accidental, reports following the aftermath of this incident cite a debilitating stigma – within and outside the health service – attached to those with HIV. They also highlight a wider problem of client confidentiality not being observed by health care professionals, as the identities of the women became widely known among their relatives and neighbours.

The Kyrgyzstan government, despite promises, has not reviewed the restrictive 2009 Religion Law, which among other things requires religious groups to undergo a laborious registration process. The government has consulted with external bodies to discuss measures, such as a ban on sending students abroad for religious education without state permission, a ban on foreigners carrying out religious practices without a state licence and amending registration criteria that would require groups to have 200 founders within the same locality; all of which would further restrict religious assembly and freedom.

By early 2012, only 135 Muslim communities and three Russian Orthodox parishes had been registered, leaving hundreds of mosques, Protestant churches, Jehovah's Witnesses and Hare Krishna communities unregistered, according to the USCIRF 2013 report. Ahmadi Muslims are also affected. In February the South Korean-based Unification Church was banned.

Uzbek imam Khabibullo Sulaimanov faced extradition to Uzbekistan at the beginning of 2013 after his arrest for illegally crossing the border in 2012. In March 2013 the courts decided not to extradite him, partly due to international pressure over the ill-treatment he would probably face in Uzbekistan. However, he is still incarcerated.

The authorities continued to target religious minority groups for 'inciting racial hatred', particularly the banned Islamist group Hizb-ut-Tahrir. The group calls for the peaceful establishment of an Islamic caliphate, but is seen as a terrorist organization by the government. In August, a Hizb-ut-Tahrir leader was arrested in Jalalabad, allegedly for planning to overthrow the government. Another imam was arrested in October for suspected membership of the group.

In January charges of inciting religious and ethnic hatred were also used against a Tengrist

for remarks he made about Islamic mullahs in a radio interview, but he denied trying to stir up religious hatred and says he is being targeted for his Tengristic beliefs. The case drew attention to Tengrism, which is an ancient Central Asian religion incorporating elements of shamanism, animism, totemism and ancestor worship. Although largely tolerated in Kyrgyzstan, some clerics claim that Tengrism proselytizes against Islam.

Tajikistan

Ethnic minorities and women are politically under-represented in Tajikistan. There are no female or minority ministers; and out of the 96 seats in the upper and lower chambers of parliament, only two are occupied by ethnic minorities and 17 by women.

In May Salim Shamsiddinov, an Uzbek community leader in southern Tajikistan's Khatlon region, was seriously assaulted after he publicly claimed the government was pursuing nationalist policies. He has since gone missing in what Amnesty International suggest was a political abduction. Elsewhere in 2012, the US State Department reported occasional harassment of Afghans and Uzbeks by law enforcement officials.

In Tajikistan 7,500 children under the age of five die every year of undernourishment according to a 2012 report by the World Bank and UNICEF. A third of children have stunted growth and there is high prevalence of anaemia and other health impacts from lack of food, according to the report. This was found to be most prevalent in rural Khatlon, with a significant Uzbek population, and Gorno-Badakhshan Autonomous Province, where ethnic Pamiris mainly live. President Emomali Rahmon's lack of connection with his people – especially minorities in these rural areas – was shown when he criticized his citizens' unhealthy eating habits and lack of exercise, which he thinks leads to high levels of obesity.

Violence erupted in Gorno-Badakhshan Autonomous Province in July, after a local state security official government official was murdered. The government sent 3,000 troops to the autonomous Pamiri region to arrest Tolib Ayombekov, an opposition leader from

the 1990s Tajik civil war who was blamed for the assassination. The violence led to numerous deaths and injuries, including among civilians, according to HRW. A majority of the region's population belongs to the Ismaili sect of Islam; representatives of the movement's spiritual leader, the Aga Khan, were involved in negotiation efforts to diffuse the situation.

Tensions continued through August, however, as local Pamiris protested after the murder of another former opposition leader, Imomnazar Imomnazarov. The government conceded that they would withdraw at the end of August but sporadic killings and skirmishes continued into September.

The Tajik government further tightened restrictions on religious freedoms in 2012, introducing new penalties for those receiving religious education abroad, preaching and teaching religious doctrines, and establishing connections with foreign religious organizations. This move led to Tajikistan joining Turkmenistan and Uzbekistan as a 'country of particular concern', according to the USCIRF 2013 report.

The report notes that restrictions and abuses primarily affect the majority Muslim population, but also Seventh-day Adventists, Baptists, Baha'is, Protestants, Jehovah's Witnesses and Hare Krishnas.

A repressive 2009 Religion Law prohibits all religious activity independent of state control. Those who participate in unregistered religious activity face up to two years' imprisonment. The 2011 Parental Responsibility Law stipulates that parents must prevent their children from participating in religious activity, outside state-approved religious education.

According to the Tajik State Department, as mentioned in the USCIRF 2012 report, only 74 of the 4,000 registered religious are non-Muslim, including Ismaili groups. Minority Muslim groups continue to face persecution; the Islamic Renaissance Party claims that numerous unregistered mosques have been demolished; the Salafi Muslim group has been banned since 2009; and in February it was reported that in December 2011 a mosque was raided for observing a Shi'a Muslim holiday when only Hanafi Sunni rituals should be observed. Muslim

women are particularly repressed since a *fatwa* or religious decree issued in 2004 banning women from praying in Tajik mosques remains in effect. Women are also banned from wearing the *hijab* in schools and government offices.

In 2012, the Tajik government arrested citizens for belonging to alleged extremist groups such as Hizb-ut-Tahrir and Jamaat-i Tabligh (Society for Spreading the Faith), which has been banned since 2006. Members dispute claims that these groups have connections to terrorism and say they belong to peaceful organizations. In May, several alleged members of the Islamic Movement of Uzbekistan were arrested and tried behind closed doors.

Uzbekistan

Only 11 members of the 150-seat strong lower chamber of government and 11 of 100 seats in the lower chamber are occupied by ethnic minorities. Furthermore, officials reserve senior government positions for ethnic Uzbeks despite laws prohibiting employment discrimination based on ethnicity or national origin.

The US State Department 2012 human rights report cites widespread restrictions on religious freedoms, including harassment of religious minority groups. The report also highlighted a government crackdown on international NGO activity and further suspicion of unregulated Islamic and minority religious groups. For example, in March security cameras were installed in more than 30 mosques in the religiously conservative Ferghana Valley. Authorities claimed that cameras were installed in order to prevent theft, but locals argue it is to ensure preachers toe the party line.

Uzbekistan remained a 'country of particular concern' according to the USCIRF 2013 report. Persecution of unregistered Christian groups was commonplace throughout 2012. For example, in December a group of Protestants were charged for discussing their faith and singing Christian songs; they also had their songbooks confiscated and fingerprints taken. In November, leaders of some registered Protestant churches were gathered in Tashkent and instructed to re-register within one month. They were also warned against missionary activity. Baptist congregations have made similar reports.

The state-run media encouraged intolerant views towards Protestants, Jehovah's Witnesses and other groups, sometimes equating their practices with extremism.

In the autonomous republic of Karakalpakstan – with a mainly Karakalpak population – only Muslim and Russian Orthodox religious communities have been registered, making the activity of more than 20 Protestant and Jehovah's Witness congregations 'illegal'. Most churches are now closed and there have been reports of Hare Krishna and Protestant students being expelled from university. Members of the South Korean-based Unification Church have been told that they cannot contact members in other countries.

Many citizens arrested for alleged religious extremism continue to end up in prison. In July 2012 ethnic Kazakh Ermek Qosmaghambetov was charged with attempting to smuggle 'materials propagating religious extremism' into Uzbekistan on his laptop. Most arrests for extremism affect members of banned religious groups Hizb-ut-Tahrir and Nur (a movement founded by theologian Said Nursi, who died in 1960), whose members comprise the majority of political prisoners in Uzbekistan. Pressure to break up 'extremist' cells has led to police and security services to use measures such as detention and mistreatment of accused persons' family members and attaining confessions through torture.

Trials rarely meet international standards and once they are incarcerated prisoners report religious discrimination. The US State Department 2012 report highlights the case of an imprisoned Jehovah's Witness reaching the end of his term and being told to renounce his beliefs or face trial once again. Also, despite periodic presidential amnesties to mark public holidays, political and religious prisoners remain ineligible.

Large numbers of prisoners are sent to the infamous Jaslyk Prison in the autonomous republic of Karakalpakstan. The institution is colloquially known as the 'House of Torture' or 'Place of No Return'. It became a destination for those charged with religious extremism after bombings in 1999 that were blamed on Islamist groups. HRW now places the number of inmates at between 5,000 and 7,000. It is well known for housing prominent dissidents and political prisoners.

As in other Central Asian states, simply

being in prison in Uzbekistan is detrimental to prisoners' health. The WHO has launched a prevention and treatment programme in prisons to stop the spread of tuberculosis as well as HIV/AIDS.

The Uzbek government claims that conditions in the jail are improving. However, a letter from an inmate – published by French human rights group Association for Human Rights in Central Asia (AHRCA) – tells of being beaten for something as minor as not showing interest in nationalist books written by President Karimov.

Sokh enclave

Sokh is a small pocket of Uzbek territory almost completely surrounded by Kyrgyzstan's Batken province in the Ferghana Valley. It is home to an estimated 60,000 people, with the vast majority ethnic Tajik and other minorities.

Ethnic tensions have simmered in the small region amid border disputes since the dissolution of the Soviet Union. Both Uzbekistan and Kyrgyzstan have a strong security presence and strict border checks.

Territorial disputes have hampered local development and the region remains one of the poorest areas in Kyrgyzstan. The Sokh enclave has been targeted by the Uzbek authorities as a suspected breeding ground for Islamic extremism. As a result large numbers of residents have emigrated, particularly to Russia.

In January 2013 ethnic violence erupted as Sokh residents attacked Kyrgyz guards erecting electricity poles in disputed territory. The ensuing riots, which spilled over into Kyrgyz territory, led to the destruction of Kyrgyz property – mainly vehicles – and almost 40 Kyrgyz were taken hostage, among them women and children.

The enclave border was sealed and barbed wire fences erected along some borders. The residents, mainly ethnic Tajiks, were cut off from the rest of Uzbekistan. Aid agencies were initially prevented from entering the enclave although restrictions were relaxed by the end of January.

Talks between the governments of Kyrgyzstan and Uzbekistan to solve the crisis quickly broke down, although Uzbekistan did agree to pay compensation in some instances to Kyrgyz citizens for damage to their property. Tajikistan also has long-standing territorial claims in the region.

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Case study
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Child marriage in Kazakhstan

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‘There were problems both during pregnancy and after the birth, but my mother-in-law thought it was nothing to worry about: it happens to many women and that’s how it should be. My mother-in-law said I should put up with all the pain.’ Child spouse, member of an ethnic minority.²

If you are a married child in Kazakhstan then you are likely to both be a girl and belong to an ethnic minority. Child spouses are those who enter marriage under the age of 18, which the UN Committee on the Rights of the Child considers to be the minimum age for marriage. In Kazakhstan, research by the UN Population Fund (UNFPA) has found this to be particularly prevalent amongst Kurdish, Turkish and Azerbaijani minorities.

Child marriage in many cases is quickly followed by pregnancy, which has the potential to cause physical and mental health problems to both the mother and infant. Girls’ bodies are less ready than those of adult women for childbearing, leading to complications during both pregnancy and childbirth.

UNICEF global figures suggest 70,000 maternal deaths of girls and young women aged 15–19 occur annually as a result of these complications. An infant born to a mother aged under 18 is 60 per cent more likely to die before his or her first birthday than an infant born to a mother aged over 18. And if the infant survives he or she is more susceptible to a range of health problems, including low birth weight, a lack of nutrition and late physical and cognitive development.

Child brides often marry older men, who because of their age are statistically more

likely to have HIV or other sexually transmitted diseases.

In Kazakhstan, child marriage is more common among ethnic minorities who follow Islam and live in rural areas. Women in such communities often occupy a subordinate position within their families and this is a contributing factor to the prevalence of the practice. Many families are also poor, and seek to marry their daughters off early in order to obtain *kalym* or bride price. Many child brides do not want to enter into the marriages chosen for them.

Child marriage is rarer in Kazakhstan than in other Central Asian states, but 2012 statistics still suggest that 1 per cent of girls are married by the age of 15 and 7 per cent by 18. Data from the Republic of Kazakhstan Agency for Statistics shows that child marriage is most prevalent among Kurds with 6 per cent of all married women being under 18, followed by ethnic Turks (4.3 per cent), Azerbaijanis (3.5 per cent) and lesser numbers of Dungan (2.5 per cent) and Uighurs (1.5 per cent). By contrast, only 0.64 per cent of married Kazakh women are under age.

In some of these communities, child marriage is an out-of-date tradition that is still the norm:

‘Early marriage is typical for the Uighur population. They believe that a girl who doesn’t marry before the age of 18 has failed.’ Child spouse, member of an ethnic minority.³

Child marriage in Kazakhstan is illegal. The legal age to enter into marriage is 18 for both men and women except in certain circumstances, such as pregnancy, where the age can be reduced to 16 but only with the consent of both parties. However, in the communities identified, many child marriages are performed by imams and remain both unofficial and unregistered, giving the girls involved few legal rights.

A lack of education in general is one social consequence of child marriage, but access to sexual health education and sexual health services are also particularly restricted. Under Kazakh law, if a 16-year-old girl seeks medical assistance, a doctor does not have the right to conduct a full medical exam without informing the girl’s parents or guardians. Often child

brides are accompanied by their husband or mother-in-law when they go to the doctor. This restricts their personal decisions about contraceptive use or treatment for sexually transmitted infections. The UNFPA research found that most girls interviewed did not know what contraception was. A preference for sons over daughters within communities where child marriage is prevalent also leads to pressure to become pregnant as many times as it takes to have a boy, before family planning is an option.

Further physical and mental health issues arise from the unequal nature of the marriage, which puts child brides at risk of domestic violence, sexual abuse and exploitation by both their husband and husband's family; many girls recount bullying from their mothers-in-law. Child brides are also at risk of becoming isolated from family, friends and their communities.

Kazakhstan has ratified both the UN Convention on the Rights of the Child (CRC) and CEDAW but failure to prevent child marriage puts the state in contravention of Article 24 of the CRC that states all children have the right to health and to access to health services; and protection from harmful traditional practices. And Article 16.1(b) of CEDAW states that women should have the right to freely choose a spouse and enter into marriage only with their free and full consent. ■

South Asia

Jack Dentith and Farah Mihar

Afghanistan

While the US and the governments involved in the NATO-led International Security Assistance Force (ISAF) are gradually withdrawing their troops from Afghanistan, serious concerns regarding human rights violations and the protection of minorities remain. At the same time, there were some overall positive developments during 2012. Civilian deaths dropped for the first time in 2012 by 12 per cent compared with the previous year, to 2,754, according to the United Nations Assistance Mission in Afghanistan (UNAMA). Over 80 per cent were killed by armed groups.

The Taliban continue to control large areas of Afghanistan, particularly in the south and the east, where the situation for religious minorities along with dissenting Muslims is insecure. In territory controlled by the Afghan government, too, there have been incidents of violations of religious freedom. In July, the case of Baljit Singh, a Sikh, raised concerns about attitudes towards religious minorities. Singh was held in detention in Afghanistan and later released over allegedly 'false claims' of being an Afghan national after having been deported from the UK, where he had unsuccessfully sought asylum. Singh described how he had been abused by Afghan security personnel and other prison inmates, and forced to convert to Islam. Singh was detained for 18 months but was never formally charged with any crime. The case shone a spotlight on both the Afghan criminal justice system and the Afghan Sikh community, which has gone from several thousand families to merely a few hundred in the last decades.

Ethnic tensions between Hazaras and Tajiks, reported for many years by MRG, remain a key issue in Afghanistan. In September 2012, a number of people were killed as violence broke out in Kabul between members of the



two communities on the day that otherwise commemorates the death of Tajik military leader Ahmad Shah Massoud, who was killed by two Tunisian men posing as journalists in 2001. A convoy of Tajiks from the Panjshir Valley passed through the largely Hazara neighbourhood of Pol-e-Sokhta; a cyclist was injured by one of the vehicles. When the police failed to act, violence erupted. The final number of casualties from the incident was not confirmed. Known as the ‘Lion of the Panjshir Valley’, Massoud is officially regarded as a national hero; however Hazaras recall a devastating attack on their community in western Kabul by his forces in the early 1990s.

There was a reminder during 2012 of a large-scale attack against the Shi’a community that had occurred during the previous year. In November, the Afghan police announced that they had arrested two persons planning a suicide bombing against Shi’a Muslims gathering in Kabul for

Above: A Hazara labourer returns home from work in Kabul, Afghanistan. *REUTERS/Adnan Abidi.*

the traditional Ashura festival. Approximately 80 people died during the attack on the 2011 procession.

Despite extensive development and humanitarian assistance efforts, continued unrest has meant that the benefits of international aid have been unevenly distributed. Conflict has had a negative impact on the health of Afghans, and the health care infrastructure throughout the country is poor – with a particularly negative impact on marginalized groups. Bamyán province, for example, has a large Hazara minority population and has faced discrimination on the part of central governments in the past. According to the United Nations Development Programme (UNDP), there are hardly any services available in the region. This has resulted in low vaccination

rates, widespread waterborne diseases, and high levels of maternal and infant mortality.

There have been mixed results from attempts to open the region up to mining in order to exploit its deposits of ores and coal. While the closure of unlicensed mines may have protected children from dangerous and unhealthy work, the Chinese firm that won the tender for mining in the region had reportedly not replaced the jobs with new ones. Reports emerged in 2012 that the lack of opportunities may have pushed people into the employment of the Taliban, which the government has vigorously denied.

Independent human rights monitoring remained in question throughout 2012, adding to the general climate of impunity that helps to keep minorities vulnerable. Posts remained vacant on the Afghan Independent Human Rights Commission (AIHRC) during 2012, including after one member was killed by a suicide bomber in early 2011 and three more were removed by President Hamid Karzai at the end of that year. A fifth commissioner was also dismissed. A landmark AIHRC study of war crimes remains unpublished, despite having been completed two years ago.

Women's rights

The situation for women in Afghanistan showed little improvement in 2012. Despite constitutional provisions on women's rights, grave incidents of violence against women continue to be reported from the country. According to HRW, in early 2012 there were 400 women and girls in detention centres for 'moral crimes', which usually involved attempts to escape forced marriage or domestic violence.

The antipathy of the Taliban towards international aid organizations and government agencies makes it difficult to assess the health of communities living in areas under Taliban control, particularly the health of women who have suffered in the past under the Taliban. In 2012, Afghan intelligence officials accused the Taliban of poisoning schoolgirls in Bamiyan province, although the accusation was denied. Similar poisoning incidents were reported in other provinces as well.

Even in urban areas under government control, vulnerable women still face big health risks, and

ethnicity has been shown to increase the risk of human rights violations for women at a drug abuse treatment centre. Recent studies suggest that Afghan women continue to face cultural, religious and social barriers to accessing health care.⁴ Issues include limited autonomy for women, preventing them from visiting clinics for check-ups, as well as a lack of emphasis on the importance of regular antenatal care. Patients also reported that the attitudes and behaviour of public health staff deterred women from using medical facilities, with abusive and disrespectful practices being reported, along with discrimination and charging for free services or medication.

Concerns about the mental health status of women and children in Afghanistan continue. With diminished rule of law and increased economic hardship, practices such as selling or exchanging girls have become more common, and domestic violence continues to be a source of distress. Establishing the social and medical structures to prevent abuse and treat women who have suffered violence remains a significant challenge in Afghanistan.

Bangladesh

Religious minorities in Bangladesh, including Hindus and Buddhists, faced a spate of violent attacks in the middle of the year that earned the country national and international condemnation. In September, dozens of Buddhist temples, at least one Hindu temple and homes and shops belonging to these communities were set alight in Cox's Bazar and Chittagong, in one of the biggest targeted attacks against places of worship in recent years. According to media reports, at least 20 people were injured in the attacks. Amnesty International quoted police as saying they had arrested around 300 people, but according to media reports tens of thousands of Muslims were involved in the attacks, sparked by the posting of a derogatory image of the Qur'an on Facebook. The government did little to protect the targeted communities. While the government condemned the attacks, they unhelpfully politicized them by blaming Islamic radicals and opposition party members.

MRG has documented continuous incidents of violence and human rights violations, including

extra-judicial killings, rape and destruction of property against indigenous Jumma peoples in the Chittagong Hill Tracts (CHT). MRG has also reported in previous *State of the World's Minorities* reports that these communities are also attacked, harassed and face land grabs from Bengali settlers in the area. In September 2012, at least 20 people were injured when Bengali settlers attacked Jumma shops and homes in Rangamati. According to some reports, the figure was as high as 60 injured. The incident was sparked by an altercation on board a college bus. Security personnel reportedly did little to stop the violence.

Bangladesh's Ahmadiyya community also continues to face harsh treatment and threats. In October, in Kisamat Menanagar, a group of Islamic extremists obstructed the construction work of an Ahmadiyya mosque. The local authorities subsequently called for construction to be suspended. On 25 October, the group conducted a procession in the area abusing and threatening the Ahmadiyya community. In early November, they made public calls for the community to renounce their religion. On 7 November, the makeshift mosque and two adjoining houses, one of which was used for prayer, were burned down. Fifteen people were injured in the incident. The community had on several occasions reportedly sought police intervention and protection but had not received any. There is a history in Bangladesh of Ahmadiis being attacked and persecuted.

In June, Bangladesh's Foreign Minister declared that the government would not be opening the country's borders, preventing the entry of thousands of the Muslim minority Rohingya people who were fleeing brutal attacks in Burma. This was in response to a request by the UN refugee agency UN High Commissioner for Refugees to keep the border open.

Referring to a widely held principle of international law forbidding forced return to situations of persecution, MRG and a group of international non-governmental organizations issued a joint statement in July saying:

'The refolement of these refugees by Bangladesh to Myanmar, where they face a very immediate threat to life and freedom, and a danger of irreparable

harm; and the manner of refolement, by push backs into dangerous waters, including in unsafe vessels are matters of serious concern.'

In July, Bangladesh ordered charities to stop giving aid to Rohingya refugees, exacerbating the already precarious health situation of these groups. Acute malnutrition rates were already critically high in the camps for registered Rohingya refugees – approximately 24,000 of the estimated 200,000 population in Bangladesh – while rates of malnutrition for the unregistered Rohingya were reported as being even higher. The Bangladeshi government refuses to recognize and register the vast majority of Rohingya who have escaped to Bangladesh from persecution in Burma. Registered Rohingya are served by inadequate health facilities in their camps, while unregistered Rohingya are essentially reliant on what they can find for themselves. The lack of aid money has meant health assessments have been impossible since the crackdown, but reports suggest that the situation of unregistered Rohingya is growing increasingly desperate.

Health

As in many South Asian countries, there is a general lack of official health data disaggregated by ethnicity or religion in Bangladesh. Nevertheless, studies from UNICEF and other international organizations help to build a partial picture of health problems faced by marginalized minority and indigenous groups.

Approximately 600,000 indigenous Jumma peoples live mainly in the CHT, one of the country's most deprived areas, and suffer particularly extreme rates of ill health. The CHT has the highest incidence of underweight newborn babies – a strong indicator of poor infant health. The amount of unmet need for family planning services (i.e. married women who want but do not have access to contraception) in Chittagong (at 21 per cent) is also the highest in Bangladesh (for which the average is 14 per cent), and contraceptive use, at 51.4 per cent, is considerably lower than the national average of 61.2 per cent.

The prevalence of malaria in Bangladesh reflects the geographic distribution of Adivasis (the term used generally for indigenous peoples).



This is largely attributable to less investment in proper housing and health services in these high-risk areas. Marginalized communities, such as the Marma tribe of Rajasthali for example, are at risk of the disease. One study found that members of the Marma community had higher prevalence of malaria, and that both the amount of forest cover and the elevation of a person's home had

strong effects on the chances of having malaria in Rajasthali.

Adivasis often live in remote areas where access to mosquito nets and health care is limited, and, on the other hand, their higher rates of poverty mean they often cannot afford health care. The remote location of Adivasi communities like the Mro make accessing health services much more

Left: Dalit woman in Bangladesh. *Livia Saccardi/MRG.*

difficult than for their Bengali counterparts. The most recent national demographic health survey showed that the CHT region, home to the Jumma peoples, had the second lowest rate of basic vaccinations in the country, at 81.8 per cent – the national average was 86 per cent.

A 2009 UNICEF study showed that Christians and Adivasi groups have higher prevalence of diarrhoea than other religious or ethnic groups, which is attributable to higher levels of poverty and lower levels of education. The incidence for Christian households was 9 per cent, whereas for Buddhist households it was 5.6 per cent; among Saontals, an ethnic group who live mostly in the Himalayan foothills, it was 12 per cent in comparison to 6 per cent for Marmas of Rajasthali. Poverty and a lack of education are shown in the UNICEF study to increase the prevalence of diarrhoea, and Christians in Bangladesh have higher rates of both.

The lack of adequate sanitation facilities in CHT and other remote areas where many Bangladeshi ethnic minorities and indigenous peoples live also impacts strongly on these differences.

Bangladesh's rush to lift itself out of poverty through a boom in manufacturing has also affected Bangladeshi health, with the tragic collapse of a garment factory in Dhaka in April 2013 reminding the world that it still has a long way to go in ensuring the health and safety of its workers. The leather industry also faced criticism in 2012 for flushing untreated waste water containing chemicals and animal flesh into the city's main river, as well as exposing children to hazardous work conditions. Minority communities, including Dalits, who often live on the margins of communities, are particularly vulnerable to the effects of such contamination.

India

Elections that took place in five states in India in the early part of the year had some significant impact on minority issues. First, the country's election commissioner announced that a much awaited implementation of a 4.5 per cent quota for jobs and seats in the education sector for

minorities would be put on hold until the elections ended.

The quota proposal suffered a further blow when in May a high court in Andhra Pradesh rejected the government order to implement the quota, saying it was designed purely on religious grounds and had no empirical data to justify the necessity for it. The central government's efforts to override the high court through the country's Supreme Court also failed, when the court refused a stay order against the Andhra Pradesh decision.

In February, Justice Rajinder Sachar, who headed the panel that produced a landmark report on Muslim education in 2006, said in an interview with the *Deccan Herald* that the government was 'fooling' minorities by promising reservations during elections when the greater need was to strengthen the education system to support minorities.

Reports of Muslims being targeted under national security laws for arrest and detention continued. According to media reports, in May, at a special meeting, Muslim leaders under the banner of All India Muslim Majlis-e-Mushawarat expressed concerns about the growing trend of Muslim youth being arrested by police on suspicion of being involved in terrorist groups. The meeting took place against the backdrop of reports that three young men – one from Bihar and two from Kashmir – had been arrested by police that month. In November, the Students Islamic Organisation of India organized a protest march in Delhi, demanding an end to the arrests. Also in November, several Muslim leaders signed a letter to India's Home Affairs Minister making the same call.

February marked ten years since the Gujarat riots, when some 254 Hindus and close to 800 Muslims were killed during communal violence in 2002 that in some areas was sanctioned and supported by Hindu extremists and politicians. The government has taken little action towards achieving justice and accountability. The state of Gujarat has not properly compensated victims and has been very slow to bring perpetrators of crimes to justice. In August, however, in a significant turn of events, a court convicted 32 people, including senior politicians from India's Bharatiya Janata Party for their involvement in



the rioting and attacks in Gujarat. The charges were for a variety of crimes ranging from murder to arson. Maya Kodnani, an ex-minister, received 28 years in jail for her role, while 30 others were given life sentences. Although the verdict caused some embarrassment to Gujarat's Hindu nationalist chief minister Narendra Modi, who held the post during the riots, he managed to win back his seat in December 2012 and remains in power.

In November, Mohamed Ajmal Amir Qassab, the only surviving gunman of the Mumbai 2008 attacks, was executed in a prison in Pune. In September, the Supreme Court upheld his death sentence but the execution happened without warning and Qassab's family was only notified later. The news of the execution sparked mass celebrations on the streets in parts of India, but human rights activists in the country and internationally were critical of the execution and the manner in which it was conducted, adding that it was politically motivated.

Arrests and detention of persons belonging to minorities and indigenous peoples under national security laws continued to take place in West Bengal. The region has been plagued by conflict

between the government of India and Maoists for decades. The Communist Party of India, minorities and indigenous peoples have been targeted for attack and human rights violations by both parties to the conflict. Violence in the state reportedly significantly decreased in 2012, according to the Institute of Conflict Management in Delhi. However, targeted violations against minorities continued. The Asian Human Rights Commission (AHRC) has reported at least five prominent cases in 2012 of torture in police custody, some from West Bengal. One was a member of the indigenous community and one was a Muslim.

In July ethnic violence in the north-east between indigenous Bodo people and Muslim settlers saw an upsurge, leaving at least 78 people killed and more than 300,000 displaced. HRW issued a statement calling on the government to rescind 'shoot on sight' orders issued to the police to quell the violence and asked that police action be taken according to international law. Violence between these two communities has been ongoing and is mainly over land and natural resources. The failure of Assam local government officials to manage the conflict has exacerbated

Left: Muslim boys from the Chowduli community catch fish in India. *Sanjit Das/Panos.*

the violence.

In August, nationwide panic swept the country based on rumours of reprisal attacks by Muslims against people from north-east India. Ethnic and tribal community people living and working in India's big cities boarded trains in their millions and fled to their places of origin in fear of being attacked.

In May, India faced its Universal Periodic Review (UPR) by members of the UN Human Rights Council. In September, the Council made a series of recommendations to India to improve its human rights record on issues including torture in police custody; repealing the Armed Forces Special Powers Act; religious freedom; and the rights of minorities and Dalits.

Many international organizations campaigned for Dalit rights issues ahead of India's UPR. Dalits, who make up a little over 16 per cent of the population, suffer consistent and continuous grave human rights violations by members of higher castes and have virtually no access to justice. In December 2012, the brutal gang rape and killing of a girl in Delhi sparked a national outcry as hundreds of thousands of women took to the streets to mourn her death and protest against violations of women's rights in the country. MRG and its partner organizations receive reports of many similar incidents of gang rape on Dalit women that go unreported and unnoticed. Attempts by victims to seek justice are often very difficult, as they face further violations and attacks by the law enforcement authorities they complain to.

Health

In India, discrepancies in health outcomes occur on the basis of region, gender and social group. Although there is a lack of health data for minority and indigenous groups, the wide discrepancies between regional provisions of services and health outcomes in India is telling. The majority of India's Scheduled Castes (SCs) and Scheduled Tribes (STs) live in rural areas, where there is worse health care provision and worse health outcomes than in urban areas. Similarly, health indicators for regions such

as Uttar Pradesh and Nagaland, which have relatively large populations of SCs/STs, are consistently poorer than for other regions such as Goa.

Infant mortality rates are 25 per cent higher for SCs/STs than for non-SCs/STs, according to a 2007 study by the UNDP. More recent studies in Andhra Pradesh show that infant mortality rates among SCs are double the national average and maternal mortality rates are 50 per cent higher than average.

According to a 2007 UNDP study, a higher number of SCs/STs have no access to public health services compared to other groups; furthermore, since 1990, in some regions, the number of people with access to health services had actually declined.

Problems with lack of health services are compounded by broader socio-economic problems faced by communities. Examples include malnutrition caused by poverty, and the inability to take time off work to travel to health facilities or see a health worker. It was calculated by UNDP that, in 2000, 23 per cent more SC children, and 27 per cent more ST children, were undernourished than their non-SC/ST counterparts nationwide.

For many groups living in remote or forested areas, who have never had access to health care services, medicinal plants and traditional healing practices are a crucial resource for their health. Yet many communities, such as the Sartang in the Monpa area and the Baiga of northern Chhattisgarh, face threats from the unsustainable exploitation of forest resources by outsiders who gather valuable plants like ginseng for trade. Forest peoples in India face a number of threats to their cultures and livelihoods, through biodiversity loss and urban migration. The unsustainable harvesting of medicinal plants simultaneously threatens the well-being of communities while withholding any compensation for resources taken from their land.

Discrimination suffered by marginalized groups also affects their health. In 2012, for example, the AHRC reported that an AHIRWAR Dalit community in Maregoan village, Madhya Pradesh was being deprived access to water and food following their refusal to carry animal carcasses; the local shopkeeper had been

intimidated into refusing to provide rations to the Ahirwar by the dominant caste, and the local water pump and communal water tank were fenced in. The AHRC similarly noted in 2012 that the dominant caste preventing access of Dalits, tribal and minority communities to government welfare schemes is a common practice in Madhya Pradesh, Uttar Pradesh, Bihar and Orissa.

This kind of discrimination and exclusion makes minority groups much more vulnerable to disease, and dramatically increases the risks of malnourishment. It also directly affects their ability to access treatment from health services. In 2000, Action Aid found that in 21 per cent of 555 villages sampled from 11 states in India, SCs were denied access to health centres. The same study found that 48 per cent of villages denied SCs access to public water or drinking places. A 2010 study by Navsarjan, a grassroots Dalit rights organization, and the Robert F. Kennedy Center for Justice and Human Rights, found that doctors in 10 per cent of villages would refuse to treat Dalit patients. A follow-up study in 2012 found that three times more Dalit children were unvaccinated against polio than non-Dalit children.

Minority and indigenous groups in India also face discrimination in the way in which their land is appropriated and their voices ignored in the drive to capitalize on India's natural resources, in particular through the mining industry. The effects of mining on health are twofold. First, removing a population from the land on which they depend without adequate compensation results in impoverishment and ensuing indirect health effects. And, second, there are the direct impacts on health from pollution resulting from the mining. The first kind of deprivation was shown in 2008, when hundreds of displaced villagers from Jagatsinghpur district in Odisha protested against inadequate compensation from Paradeep Phosphate Ltd. The second kind has been demonstrated across India, from reproductive health problems due to uranium mining in Jharkhand to skin disorders associated with bauxite mines and refineries in Orissa and Andhra Pradesh.

The well-publicized case of the indigenous Dongria Kondh's battle with the UK mining

company Vedanta Resources and its Indian subsidiary's plans to open a mine on land held sacred by the local community had a positive moment in April 2013, however, with India's Supreme Court ruling that the indigenous communities will have the final decision on any bauxite mine plans

The ongoing unrest in Jammu and Kashmir has also had drastic health consequences for the population there. Violence or the threat of physical violence continue to have significant effects on mental health, with a number of studies in recent years identifying high prevalence of mental health problems, from post-traumatic stress disorder and bipolar disorder to high levels of generalized anxiety, panic and phobia.

The increased presence of the military also makes it difficult for some people to access health care. Nomads like the Gujjars, who traditionally live in higher altitudes, have been left unable to access facilities, or unable to sustain their livelihoods due to restrictions on movement and access to land. One study, published in 2012, revealed that 39 per cent of the Gujjar community had relinquished their migratory tradition during the past two decades of conflict.

Nepal

The deadline to agree on a new constitution expired in May as members of the country's Constituent Assembly failed to come to an agreement. Then Prime Minister Baburam Bhattarai, member of the Maoist Party, went on to dissolve the Assembly, but elections were not held in 2012. The Assembly had also served as the country's parliament.

One of the major areas of disagreement for members of the Constituent Assembly was on the issue of creating federal units based on ethnicity. This is a major demand for some minority communities that want greater self-rule in their areas. However, the large numbers of different ethnic groups in Nepal and their geographical dispersion has complicated the issue. The failure to reach agreement on this issue and the subsequent dissolving of the Constituent Assembly has left Nepal in political deadlock. The country effectively spent much of the year without a legislature. More concerning is that the constitution-making process linked to

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Case study by *Dr Audrey Prost, Dr Prasanta Tripathy and Soumendhra Sarangi*
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Power of participation: women's groups dramatically improve health for Adivasi mothers and newborns in eastern India

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Involving Adivasi women in the planning and evaluating of health care has significantly reduced deaths and empowered women among India's Adivasi communities in Jharkhand and Odisha.

Over 84 million Adivasis (original inhabitants) from more than 500 tribal groups live in western, central, eastern and north-eastern India. Today a quarter of all Adivasis reside in the central and eastern states of Jharkhand, Odisha and Chhattisgarh. Traditional Adivasi livelihoods revolved around the use of forest products and cultivation (both shifting and upland). Laws imposed under the British administration led to the widespread nationalization of forests and subsequently large forest areas were contracted to private companies. Adivasi ownership of land and resources has yet to be addressed through government legislation, such as the recently enacted Forest Act. Because of this, and large infrastructure projects such as the construction of dams, Adivasis now constitute over half of India's displaced people. Adivasi homelands also span some of the world's largest mineral reserves, but

indigenous communities have yet to reap the social and economic benefits of mining-related development. In eastern India, competing claims over existing natural resources are increasing the risk of conflict.

Amidst this charged political backdrop, Adivasis remain the poorest socio-economic group in India, with low literacy and the highest maternal and child mortality rates in the country. The risk of an Adivasi child dying before the age of five is 25 per cent higher than that of a non-tribal child, and the maternal mortality ratio (MMR) in tribal areas of Jharkhand and Odisha is three times the national MMR.

Although access to quality health services is critical to saving mothers and infants, in tribal areas of Jharkhand and Odisha around half of women still deliver at home, and fewer than 20 per cent access postnatal care. This is because of the remoteness of tribal villages, concerns about the costs of health care and fear of discrimination at the hands of non-Adivasi professionals. There is also a lack of information about simple prevention strategies and care for common problems during pregnancy, childbirth and the postnatal period.

Fortunately, in some areas this is beginning to change through processes led by Adivasi women themselves. Since 2005, the civil society organization, Ekjut (meaning 'coming together'), has worked with women's groups to improve maternal and newborn health in remote tribal areas of Jharkhand and Odisha. Building on a methodology first developed with the indigenous Aymara community of Bolivia, Ekjut selected local female facilitators to support 244 women's groups to meet every month as part of a participatory learning and action process. During these sessions women identified common problems they faced in pregnancy and after giving birth. They also found feasible strategies to address these problems and evaluate the results. The facilitators were not health workers but local women whom others could trust and relate to. They were given training in participatory communication techniques and basic knowledge about maternal and newborn health. The women's groups discussed common

Case study continued

problems using role plays, picture cards and storytelling, followed by reflection and analysis. The groups also organized large community meetings to share their priority problems and enlist the support of other community members to implement their chosen strategies. These activities were meant to improve individual and community knowledge of maternal and newborn health, but also foster reflection and the confidence to change existing practices.

The intervention had hugely positive results. The impact of the women's groups was evaluated using a cluster-randomized controlled trial, published in a leading medical journal. An indigenous demographic surveillance system was used, in which local women reported births and deaths among women of reproductive age in their communities. A data collection team interviewed women who had recently delivered to find out about events around the time of birth. The women's groups led to a 32 per cent reduction in neonatal mortality (deaths in the first 28 days of life), significant improvements in hygienic practices at the time of delivery and increases in exclusive breastfeeding.

At the end of the trial, Ekjut decided to introduce the women's group intervention into control areas for ethical reasons. Neonatal mortality fell sharply in the control areas, and an estimated 500 newborn infants have been saved through these interventions since 2005. Further analyses also showed that the groups had succeeded in attracting the poorest mothers and mortality reduction has been greatest among the poorest.

After these early successes, Ekjut is also adapting the participatory learning and action method to address other pressing health issues, including the prevention of childhood illnesses and under-nutrition, and carrying out new evaluations. Ekjut have also supported a scaling up of the intervention through their own facilitators and other actors. The government of India's flagship National Rural Health Mission programme now supports women's groups facilitated by accredited social health activists in several areas of Jharkhand, and other agencies

are implementing the participation learning and action cycle with self-help groups in Bihar and Odisha.

There are a number of lessons from this work. First, women can be catalysts for change. Many organizations and governments endorse the right to participate in the planning of health care, but methods to ensure this are rarely evaluated, and tribal women are seldom in control of the process. Using participatory methods to involve Adivasi women in planning and decision-making resulted in substantial reduction in mortality and a significant sense of empowerment among women. In the first local elections held in the areas where Ekjut implemented the programme, several facilitators of the women's groups won seats as people's representatives, testifying to women's increased confidence.

Second, good evaluation pays off. Many organizations do outstanding work to improve health among indigenous communities but low-cost surveillance systems and evaluation methods lend credibility to demands for scaling up. Finally, scaling up interventions is often not – and need not be – a linear process: change happens in many ways, and so efforts to scale up interventions require long-term commitment and flexibility. Today, combined with increased government efforts to strengthen health services and a national conditional cash transfer scheme to increase the uptake of institutional deliveries (Janani Suraksha Yojana), women's groups from Jharkhand and Odisha are paving the way to a better future for Adivasi mothers and their newborn babies. ■

Endnotes

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peace-building has been stalled, which does not augur well for a country that has been out of conflict for a relatively short period. Furthermore, the continuum between the old Constituent Assembly and the new process is unclear, leaving in doubt the impact of the groundwork done by minority and indigenous members of the former Constituent Assembly and civil society groups on minority rights promotion and protection.

A further pressing issue is lack of accountability. While in August the Council of Ministers proposed a Commission of Inquiry on Disappeared Persons, Truth and Reconciliation, the Commission was reportedly granted powers to recommend amnesties but not prosecutions. The situation was exacerbated by a number of high-profile appointments of persons alleged to have committed serious human rights violations. Amnesty International noted that this climate of impunity was a particular problem in the Terai region, where it reported abuses by the security forces, police and armed groups. Fear of reprisals prevented victims from coming forward.

Human rights protection in the country was further affected when, in March 2012, the Office of the High Commissioner for Human Rights (OHCHR) field presence was formally shut down after the Nepali government refused to extend its mandate. They also refused to allow an OHCHR staff member to be housed in the country's UNDP office. This removal of the UN human rights office has left a vacuum in international human rights monitoring and reporting.

Caste-based, ethnic and religious discrimination continued to be reported. In October, Bhim Bahadur, a Dalit from Dailekh district, sustained severe injuries after having been attacked for touching the front door of a house belonging to a person of a dominant caste. Dalits experienced restrictions on their religious freedom; Hindu priests and villagers prevented Dalits from entering temple precincts and participating in Hindu festivals. Christian groups reported receiving threats from Hindu extremists; these were usually linked to extortion.

The rights of Tibetan exiles and Nepalis of Tibetan origin continued to be curtailed, particularly with regard to public assembly and

celebrations of Tibetan holidays. In March, for example, the authorities arrested 100 Tibetans who were protesting to mark the 53rd anniversary of the Tibetan uprising. These restrictions appear to have been imposed at the behest of the Chinese government.

Health

Although Nepal's 2012 demographic health survey did not provide data about inequalities across caste or ethnic groups, previous population surveys have indicated serious disparities between the health of minority populations and that of the population at large.⁵ The life expectancy of a Hill Brahmin was 68 years, while for a Hill Dalit it was only 61 in 2009, according to UNDP. In 2001, UNDP found that upper-caste Brahmins and Newars live, on average, between 11 and 12 years longer than Dalits and Muslims.

Disadvantaged minority groups face difficulty in accessing health services in Nepal, due to geographical remoteness, social stigma, or refugee status. Marginalized groups, including Dalits and indigenous Janajatis, face barriers to accessing family planning services due to their illiteracy (which may prevent them filling in required forms), poverty (which may prevent them from paying for services), or their low social status (as a result of discrimination on the part of health workers). The very distribution of health workers is, in the first place, highly unequal across regions.

A number of factors that contribute to health outcomes, such as sanitation, nutrition and access to health care, are marked by significant disparities between rural and urban populations that recent Nepalese surveys have captured. These factors disproportionately affect ethnic minorities, who make up a higher portion of the population of Nepal's rural regions.

A number of sources suggest that insecure access to food and water is especially pronounced for indigenous groups, especially in mountainous regions, as well as for Dalits in Nepal. As a result, disadvantaged minority groups are more vulnerable to disease and malnutrition.

Maternal mortality for Muslims, Terai Madhesi and Dalit groups is higher than for other social groups. These rates are linked to the

comparative lack of access to pre- and post-natal care for marginalized groups.

The latest figures from Nepal's Demographic Health Survey, in showing sharp disparities in child mortality between the far-western and eastern regions, strongly suggest that these trends have continued to create health differences between ethnic groups. Similarly, under-five mortality rates among Dalits are higher than among any other group, and well above the national average (95 out of 1,000 Dalit children do not survive to their fifth birthday, while for Newar children the figure is 43).

Although a 2012 Samata Foundation study in Sapatri district found that health workers do not in general discriminate against low-caste members at the point of service delivery, there is believed to be more widespread discrimination in terms of access to information about health care that Dalits in Nepal have, as well as health workers requiring increased interest rates or fees for services.

Dalits also suffer discrimination in accessing water due to their untouchable status. The AHRC reported in 2012 an instance where the non-Dalit community in Koteli village, Dadeldhura district prevented the water from flowing to Dalit households. The affected villagers, particularly women, have to walk five hours to fetch water – back-breaking work that causes stress as well as physical problems, and takes time away from crop cultivation.

For refugees in Nepal, the situation in terms of accessing health resources remains precarious. One study of Pakistani and Somali refugees noted that, given the lack of attention to or budget for mental health care for the population at large, provision for refugees was negligible. For Tibetan refugees, the Nepali government's recent rejection of a plea to grant them identification papers represents a major obstacle to their ability to secure livelihoods and access essential services.

Pakistan

Pakistan has become one of the deadliest countries in the world for ethnic and religious minorities. In 2012, targeted attacks against the country's minority communities rose significantly, with little or no action taken by the government to protect them. In September

2012, HRW reported that 320 members of the Shi'a community had been killed during the year, noting that this was an escalation of the violence against the minority. Most of the attacks in the largely Sunni country were targeted ones by militant groups such as the banned Lashkar-e Jhangvi. In one of the attacks in August, gunmen ambushed a bus, searched ID cards, singled out Shi'as and shot them dead, HRW said. Violent attacks against Shi'as increased again towards the latter part of the year, as the community marked its major religious festival, Ashura. In the run-up to the event at least 30 people were killed and over a hundred injured in a series of bomb attacks in Rawalpindi and Dera Ismail Khan. Seven children were killed in one attack on 24 November.

Many of the attacks on Shi'as were targeted against ethnic Hazara living in the conflict-affected Baluchistan province. According to media reports over 100 Hazara were killed in Baluchistan in 2012. The Human Rights Commission of Pakistan (HRCP) reported that there were 213 incidents of sectarian-related attacks in 2012, which killed 583 people and injured 853.

Intolerance towards other religious minorities in Pakistan continued to be reported throughout 2012. In August 2012 the AHRC reported on a rise in emigration of Hindus from Pakistan's Sindh Province to India. The AHRC noted that large numbers were fleeing the country due to the increase in incidents of religious intolerance. The exodus was believed to have been prompted by the abduction and forced conversion of a 14-year-old Hindu girl to Islam in Jacobabad, in Sindh. Earlier in the year, in Mirpur Mathelo, a 17-year-old Hindu girl was allegedly abducted, forcibly married and forcibly converted. The AHRC reported that the case was brought before a civil court, where the girl, Rinkle Kumari, was slapped and abused, and, despite her pleas that she wanted to return to her parents, the girl was converted to Islam. Her family was threatened and forced to accept the conversion. Kumari's case was later heard by the Supreme Court, which ruled that the girl should choose. The question raised by human rights defenders and community spokespersons was whether her decision ultimately to remain with her husband

could truly be voluntary. While the facts of the case remained disputed, it drew considerable media and political attention to the situation facing religious minorities in the country.

In September, a young Christian girl, Rimsha Masih, who suffers from a learning disability, was held on remand in an adult prison for blasphemy and accused of damaging parts of the Qur'an. Several weeks later, Rimsha was freed on bail after witnesses had stated that she had been framed. Under Pakistan's oppressive blasphemy laws, bail is normally not permitted; Rimsha's lawyers had pleaded for her release, however, on the basis that the girl was a juvenile. An imam in the area was subsequently arrested for planting burnt pages of the Qur'an in the girl's bag. The case was finally thrown out of court. Rimsha's plight highlighted how the blasphemy laws can be abused by individuals.

Despite increasing national and international condemnation, Pakistan has done nothing to remove these laws. In November, when Pakistan was reviewed by the UN Human Rights Council under its four-year UPR, more than 15 countries raised concerns over the laws and asked for them to be repealed. Several international organizations, including MRG, drew attention to the difficult and threatening conditions under which religious minorities live, having to face killings, abductions, attacks, rape, forced conversion and extortion, many of which are conducted by members of violent religious extremist groups but commonly supported by state agents and enabled by the legal system.

Pakistan's Muslim minority Ahmadiyya community continued to face intolerance throughout the year. In August, the local Ahmadiyya community was prevented from attending religious prayers to mark the Eid-al-Fitr festival in Rawalpindi. In December, masked men desecrated an Ahmadiyya grave site, in Lahore, breaking down and destroying over 100 gravestones. A similar incident had occurred in Faizalabad earlier in the year. No action was taken by the police following these incidents. The Islamist Tehrik-e-Khatme Nabuwat organization had previously pressured the police to remove Islamic inscriptions from the gravestones. Earlier in the year, this group had held a conference in Lahore that had called

for the banning of the Ahmadiyya community in Pakistan. According to the HRCP at least 20 Ahmadis were killed in 2012 because of their religious identity.

Baluchistan, where ethnic Baluchis are fighting for a separate state, has long seen large-scale human rights violations. In August 2012, following a fact-finding mission, the HRCP said the situation had shown little improvement in the past year and serious violations, including enforced disappearances, continued to be reported amid widespread impunity in the province. The HRCP stated in its annual report that 125 mutilated bodies had appeared in the first 10 months of the year; in addition, the HRCP recorded 34 disappearances; while 26 people were traced and released, the remainder are still missing. The HRCP argued that the human rights situation in Baluchistan should be seen more broadly beyond the conflict with the Baluch independence movement, given the increased targeted attacks against Hazara, other Shi'as and other religious minorities in the province.

Violations also continued to be reported from Pakistan's Federally Administered Tribal Areas (FATA), which are also affected by conflict. HRW reported that thousands of people arrested in 2009 in the Swat valley and FATA on suspicion of being involved with the Taliban remain in custody under anti-terrorism laws. This area is particularly affected by internal displacement due to the conflict. In September 2012, aid agencies warned that due to the protracted conflict around 400,000 children displaced because of the conflict were at risk from malnutrition and disease.

Health

Pakistan is not expected to meet the child mortality target set for 2015. At present, the number of deaths of children under one year of age per 1,000 live births is 75, against the Millennium Development Goals (MDG) target of 40. Attaining high immunization coverage for childhood diseases is an important intervention with regard to reducing child mortality. However, less than half of Pakistan's children are fully immunized. Immunization coverage has actually fallen in all the provinces except Punjab,

with the sharpest decline seen in Baluchistan (19 per cent).

In December 2012, nine health workers vaccinating children against polio were shot and killed in Karachi and Peshawar. Pakistan is one of four countries in the world where new polio cases were still emerging, despite a massive nationwide immunization programme. There were 58 reported cases in 2012, down from 198 cases in 2011. Misinformation about the immunization programme led some Islamists and Muslim preachers in Pakistan to say the polio vaccine is a western plot against Muslims. The killing of the health care volunteers in December was a major setback to the effort to reach full immunization coverage for polio and resulted in the UN calling off the campaign.

Malnutrition contributes to 35 per cent of under-five deaths and more than 40 per cent of children are either moderately or severely stunted; malnutrition rates in two provinces are above emergency levels. The national nutrition survey of 2011 reveals that Sindh is the poorest and most food-deprived province, with 72 per cent of families being food insecure. It is followed by Baluchistan, where 63.5 per cent of families are food insecure.

Pakistan's maternal mortality ratio has declined, from 400 per 100,000 in 2004–5 to 276 per 100,000 in 2006–7, but meeting the MDG target of 140 per 100,000 will require further immense resources and efforts. The maternal mortality ratio in Baluchistan is

shockingly high, at 758 per 100,000 live births.

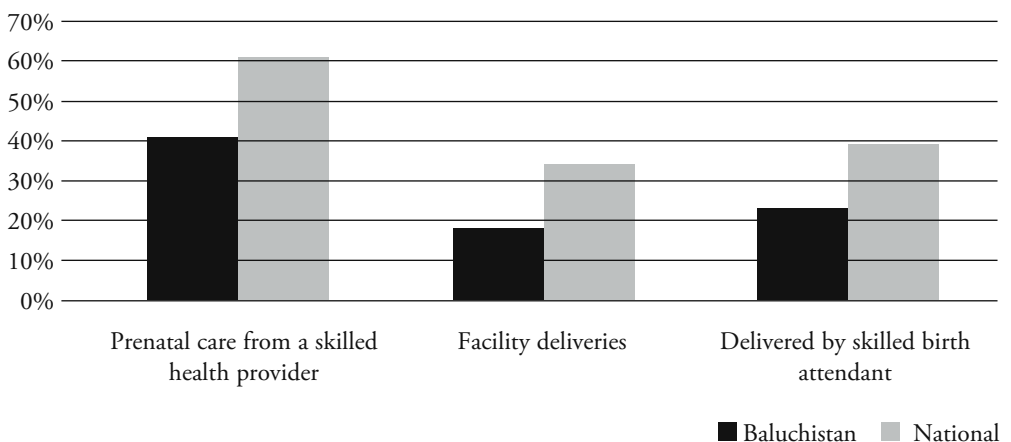
Cultural practices of ethnic minorities living in Baluchistan do not allow women to seek services/information from male health staff. The majority of Basic Health Units in the province are reported to have no female health workers. Almost a quarter of the Basic Health Units do not have personnel to offer family planning counselling or other services; almost 40 per cent do not have a maternity kit; and almost half do not have a labour room. Geographical disparities can be seen across the country, especially between Punjab (with the most personnel and facilities to serve women) and Baluchistan (with the least).

Sri Lanka

Minority rights remain critically challenged in Sri Lanka as the country's human rights situation deteriorated further in 2012 in a climate of impunity. Serious human rights violations, such as abductions, arbitrary arrest and detention, torture and sexual violence continue to be reported from the country's former conflict areas, which are considered the homeland of the ethnic Tamil minority.

These areas remain heavily militarized; in addition to checkpoints blotting the region, the military also runs businesses, farming and development projects, and controls civil society activity in these areas. There is very limited freedom of expression or assembly in the country's north and east and, while people are allowed to move in and out of the area, they

Maternal health status in Baluchistan compared with national figures



are heavily monitored. Tamil women in the country's north are especially vulnerable in these situations.

In March 2012, the Regional Director of the Jaffna Hospital, Sinnaiah Savaroopan, reported to the BBC that in the previous two months there were 56 cases of rape and severe violence against women and girl children reported to his hospital. MRG's partner organizations working in northern Sri Lanka say they receive a number of complaints of sexual attacks, violence and abuse, in some cases by the military, but frequently women are afraid to make formal complaints. They also say women are coerced into sex work and/or sexual relationships with military personnel to gain access to resources or services. There are also major development projects taking place in the north and east without consultation with local communities, and there are serious concerns regarding land acquisition and land-grabbing by state agents for development projects. Large sections of minority lands remain under military control with no access for civilians.

In 2012 there were also notable targeted attacks against minority rights activists, human rights defenders and media personnel. Paramalingham Tharsanath, secretary of the students' union of the University of Jaffna, was brutally assaulted by masked men close to a military checkpoint in Jaffna.

The year 2012 also saw a new wave of widespread targeted attacks against minority Muslim places of religious worship and business establishments by extremist Buddhist groups and monks. In April 2012 a mosque was attacked in the north central town of Dambulla, and subsequently the government issued demolition orders for the building. There has been a national campaign against Muslim religious practices, including on 'halal' certification for food. There is evidence of state involvement or at least complicity in the attacks and police inaction during the attacks. Attacks against Christian religious places of worship, particularly Evangelical churches, continued to be reported throughout the year, especially in the south of Sri Lanka.

At the end of 2012 the Sri Lankan parliament began impeachment proceedings against the

country's Chief Justice, Shirani Bandaranayake, on corruption allegations that she denies. Sri Lanka's highest court ruled that the proceedings were illegal, and lawyers and civil society activists took to the streets for days, protesting against the move and warning against interference with the judiciary and breakdown of rule of law. Despite national and international condemnation, the Sri Lankan parliament voted Bandaranayake out and she was sacked from her position by the President in January 2013.

Hardly any effort has been made by the Sri Lankan government on issues of accountability, justice and reconciliation. Over three years since the end of the armed conflict thousands of victims, including families of the disappeared, are awaiting justice in Sri Lanka. Attempts by family members, women especially, to seek justice or simply mourn for their dead have been brutally obstructed by the government. In March 2012 the United Nations Human Rights Council passed a resolution on Sri Lanka, calling on the government to do more to protect human rights and to implement its own Lessons Learnt and Reconciliation Commission (LLRC) report recommendations.

Sri Lanka's national-level performance on health is generally quite good compared to other South Asian states, but minority areas have poorer health outcomes. Available national statistics on Sri Lanka are from 2006, released in 2008 in the Demographic and Health Survey (DHS 2006); they indicated higher levels of child malnutrition in the former conflict areas in the east of the country. The survey was not conducted in the north at the time as the armed conflict was taking place. In the former conflict-affected districts, such as Trincomalee, 28.1 per cent acute and 30.5 per cent chronic malnutrition was recorded among children, which is higher than the national average. These figures are expected to be much higher in the country's north, where access to medical care was limited for nearly three decades.

According to the UNDP 2012 Human Development Report, the four districts with the highest rates of maternal mortality were areas with high levels of minorities. The maternal mortality rate in the northern town of Killinochchi was 102 per 100,000 births as



Above: Tamil tea plantation workers, Sri Lanka. *MRG.*

against the national average of 39.3.

Several thousand, including children, also faced permanent physical injuries received during the last stages of the war and have faced varying degrees of trauma and mental illness. Due to the government's position that there were minimal civilian casualties in the conflict, many of these people are not receiving the required medical attention and psychosocial support. NGOs and other organizations providing counselling are strictly monitored by the military, and sometimes attacked on the grounds that they are collecting evidence to support international allegations of war crimes. Following the conflict, many female-headed households are facing high levels of poverty, which is also likely to affect the health conditions of women and children in these areas.

Plantation areas where most Tamils of Indian origin live have some of the worst health

statistics. The health care facilities available to plantation workers are inferior to those available in other sectors. One health facility must serve the inhabitants of multiple plantations, which means the facilities are overextended and lacking in resources. The plantation workers face a variety of risks (mechanical, medical, etc.) as a part of their daily lives. The health care facilities in place do little to help those who have been severely disabled by their working conditions (e.g. back, leg, heart injuries). The increase in the use of pesticides on the plantations has had adverse effects on the workers, including the spread of disease. Despite these dangers, the workers are not offered any additional health care outreach.

Within family planning programmes, maternal and child mortality rates are particularly high. Expecting and new mothers are of low body weight and give birth to underweight and undernourished infants. Mothers lack adequate pre- and post-natal nutrition education.

South East Asia

Irwin Loy

As the world nears the 2015 deadline to achieve the Millennium Development Goals, events in South East Asia during 2012 underscored the unequal progress that has been made in many countries. In many parts of the region, there are troubling and consistent gaps in health outcomes between the majority and the often marginalized minorities. In eastern Burma, maternal health remains dire for minority women in conflict zones, despite hopeful but tenuous ceasefires. Incidence rates of HIV soar unacceptably high above the national average in Indonesia's Papuan provinces. In the Philippines, a pair of calamitous natural disasters exposed an uneven response to survivors, while maternal and child health indicators in parts of conflict-torn Mindanao have actually worsened. Meanwhile, in Vietnam, researchers say the gap in access to maternal health is widening – and it is largely drawn down ethnic lines. The year's events show that basic rights for minorities are not an inconsequential ideal – they have a direct impact on health and lives.

Burma

During 2012, Burma continued to re-engage with the international community following years of isolation. The government continued its gradual release of political prisoners, touted tenuous ceasefire agreements with armed ethnic militias and lifted aspects of its once crippling media censorship.

In April, the country held by-elections to fill vacant parliamentary seats. Opposition figure Aung San Suu Kyi ran and won her seat, less than 18 months removed from long-term house arrest. Critics charged that the government was using a by-election – in which its control of power was never in doubt – as a modest show to encourage the lifting of international sanctions. Indeed, the United States and European Union

began to ease sanctions following the vote. Observers such as the Alternative Asean Network on Burma noted 'widespread irregularities, threats, harassment, vote-buying and censorship'.

In three constituencies of conflict-ravaged Kachin state, authorities postponed the vote altogether. Nevertheless, the international community responded positively to the by-election. Still, the well-being of Burma's diverse and numerous ethnic minority groups is necessarily a measure of the extent of the country's reforms.

Throughout the year there were worrying developments, including anti-Muslim demonstrations and violence, the continued persecution of ethnic minorities in conflict zones, and the marginalization of minority communities in tenuous ceasefire areas. In each case, the instability had detrimental effects on the health of already marginalized populations. In eastern Burma, for example, the maternal mortality rate is triple that of the country as a whole, making this statistically among the most dangerous places in the world to be a pregnant woman. At the same time, drug-resistant malaria is spreading along this eastern border heavily populated by minority groups. It now means that Burma accounts for more than half of all malaria-related deaths in South East Asia, according to *The Lancet* medical journal.⁶

The dire health situation in such areas is exacerbated by long-standing conflicts, which displace and destabilize civilian populations. Fighting continued between the Burma Army and the Kachin Independence Army through the year, following the crumbling of a 17-year ceasefire in 2011. Numerous attempts at peace talks failed to produce an end to the violence. In the meantime, civilians caught in the crossfire continued to suffer. A March report from HRW accused government soldiers of blocking needed humanitarian aid, torching villages and firing on innocent civilians. Rights groups say the conflict has displaced as many as 75,000 civilians. A further 10,000 who attempted to flee to China were denied basic care, including safe water supplies, food, sanitation and health care, HRW reported in June.

Also in June, the Kachin Women's Association Thailand (KWAT) said it had documented



Above: Rohingya families living in basic home-made shelters in Rakhine state, Burma. *Mathias Eick EU/ECHO.*

cases in which 43 women or girls were raped or sexually assaulted in the 12 months leading up to June 2012. Burmese soldiers, the report stated, 'have used rape systematically as a weapon of war'. A later report documented the killings or injuries of 26 civilians between September 2012 and February 2013.

In Karen state in eastern Burma, the government touted its ceasefire with the Karen National Union (KNU) and its military wing, the Karen National Liberation Army (KNLA). But a May report by the Karen Human Rights Group (KHRG) detailed abuses post-ceasefire, either at the hands of the Burma Army or the Democratic Karen Buddhist Army (DKBA), a splinter faction of former KNLA fighters. These

included allegations of arbitrary arrest, physical violence and forced labour.

In Shan state, a short-lived ceasefire with the Shan State Army North (SSA-N) broke down in June as the rebel group clashed with the Burma Army. In December, the Shan Women's Action Network (SWAN) said civilians were frustrated by the continuing violence despite a more than year-long peace process.

One of 2012's most worrying developments was the surge in violence between Buddhists and minority Muslims. This was centred in troubled Rakhine state, where tensions between ethnic Rakhine Buddhists and Rohingya Muslims spilled over into bloodshed. Though violence often grew from back-and-forth retaliations, it quickly developed into a humanitarian crisis with tens of thousands of mostly Rohingya Muslims driven from their homes. In May, a Rakhine woman was raped and murdered; the assailants

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Despite the ceasefire, health care woes continue in south-eastern Burma

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In a bustling waiting room, Naw sits on a fold-up chair, her hair caught in the breeze of a whirling fan.

Her arms rest over the bump just beginning to show beneath her clothes. This will be the eleventh time she has been pregnant. However, it is the first time she will actually consult with a health professional during the sensitive prenatal months.

For many like her, the Mae Tao Clinic in the western Thai town of Mae Sot along the Burmese border is the only opportunity to access reliable health care.

‘When I was in the countryside in Burma, there would be only one midwife for the entire village,’ says Naw, who asked that her name not be published. ‘If I wanted to get proper health care, I had to go to a big city and spend money.’

It is a vital issue in south-eastern Burma, which has suffered from years of clashes between Burmese troops and armed ethnic militias fighting for autonomy. That includes decades of fighting over the border in Karen state, where many of the patients who cross the border to reach the clinic live.

The instability means the maternal mortality rate in south-eastern Burma – describing the rate of women who die during pregnancy – is more than three times the national rate, at 740 deaths per 100,000 live births.

Mortality rates for infants and children under the age of five are also

disproportionately high. Naw, who lost four of her children before they were five years old, says she feels safer having a baby here in this clinic. That’s why she pays for transport across the Moei River, which acts as a natural border here between Thailand and Burma, so she can reach the clinic on the Thai side.

Naw says, ‘I’m not young any more. I know I’m old to be having a baby. I should be delivering in a proper health centre.’

The year 2012 began with hopeful news in Naw’s native Karen state: the announcement of a ceasefire between the Burmese government and the Karen National Union (KNU), who have been engaged in one of the longest-running civil wars in the world.

An October survey from The Border Consortium (TBC), an umbrella organization of international groups delivering aid to Burmese refugees in Thailand, estimated that 10,000 people were displaced in south-eastern Burma during 2012. It is still a worrying figure, but far less than the estimated 75,000 a year that had been recorded prior to this.

Even as hostilities cooled during the year, however, the health situation remains perilous. The TBC survey suggested almost three-quarters of people in the south-east’s rural areas do not have access to safe drinking water, while almost half cannot access proper latrines.

While Burma has boosted funding for its health services recently, the national health budget still comprises only 3 per cent of total government expenditure, according to medical journal *The Lancet*.⁷ People like Naw have turned to the international community, through the Mae Tao Clinic, which has a target population of about 150,000 people on both sides of the border.

For others, who cannot reach the clinic, the situation is often dire. Groups like the Backpack Health Workers Team, based in Mae Sot, are trying to take health care to those who need it.

For years, the group has sent mobile teams into remote areas to deliver health care. In just the first six months of 2012, health teams dealt with more than 45,000 individual cases.

Mahn Mahn is the group’s director. He says last year’s KNU ceasefire has made travelling in

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the region easier for health workers. But even with a ceasefire, health problems are just as worrying. Preventable illnesses like malaria, diarrhoea and acute respiratory infections are still prevalent in the target area. At the same time, aid workers say the relative calm has sparked a renewed interest in large-scale development projects, particularly in the mining sector. There have been more reports of land confiscation as proponents of these development projects are

Below: Karen amputee at the Mae Tao Clinic in Thailand, found along the Burmese border.
Brendan Brady.

eager to take advantage of the relative calm.⁸

Mahn Mahn says, 'There are direct health impacts, but also indirect ones from land confiscation, conflicts between locals and workers.'

Mahn Mahn says he hopes a permanent end to the fighting will see the health situation improve. However, the path ahead remains difficult.

'We see only the ceasefire, but we don't see the peace process clearly. We need to see what the peace process will be in order for the political situation to stabilize. Without solving the political situation, the ceasefire is not sustainable.' ■



were reported to have been three Muslim men. A week later, an incensed Rakhine mob attacked a bus and beat to death 10 men perceived to be Muslim. The violence sparked a series of retaliatory attacks. According to official estimates, the attacks left 80 people dead and displaced a further 90,000, mostly Rohingya, by the end of the month.

Aid workers warned of a burgeoning 'humanitarian crisis' for Rohingya Muslims fleeing the violence. Conditions in temporary camps were described as 'alarming', with health experts expressing particular concern over malnutrition rates among displaced Rohingya. The violence saw many Rohingya attempt to flee Burma in boats, only to be turned back by neighbouring Bangladesh, where tens of thousands of displaced Rohingya already live in official and unofficial refugee camps. In a June report based on interviews with fleeing Rohingya, the UK-based Equal Rights Trust charged that the military had not only turned a blind eye to the violence against Rohingya, but that it had actively participated in 'state-sponsored violence' against them:

'The military became more actively involved in committing acts of violence and other human rights abuses against the Rohingya including killings and mass-scale arrests of Rohingya men and boys in North Rakhine State. This has caused an increased proportion of men and boys to flee the country, resulting in increased incidences of rape of the women left behind, committed by Myanmar security personnel.'

Violence again erupted in October, leaving more than 100 people dead, according to official estimates. HRW suggested that the death toll could be far higher. While there has been violence on both sides, human rights groups warn that many of the consequent attacks have been focused on Rohingya communities, often with the complicity of a government unwilling or unable to protect them. For example, HRW released satellite images following the October attacks showing whole villages belonging to Muslim families burned to the ground.

The stateless Rohingya are often called 'the

most persecuted people on earth' – refused citizenship by Burma, and unwanted by neighbouring Bangladesh. While the antipathy in Burma has been cultivated by outspoken extremist Buddhist monks, ordinary citizens have also participated in large anti-Rohingya and anti-Muslim gatherings. This was highlighted by an October demonstration in the capital, Yangon, when thousands of monks marched in the streets to protest the Organization of Islamic Cooperation's stated plans to help the Rohingya. Violence between majority Buddhists and minority Muslims flared elsewhere in Meikhtila in central Burma in March 2013. Media and rights groups reported on a massacre of at least 25 Muslims in late March.

The future prospects for long-term peace in Burma's disparate ethnic regions are inextricably tied to the government's renewed push for the development of the country's natural resources. But critics say the push for development in these still sensitive areas has brought with it increased militarization. A November report by the Ta'ang Students and Youth Organization (TSYO) highlighted problems associated with the controversial Shwe Gas Pipeline, which will allow the shipment of oil and gas between China and the Bay of Bengal. Burma has deployed additional military units to guard the pipeline route, amid pressure from armed ethnic militias. The pipeline's construction has led to land confiscation, forced labour and other rights abuses, the report states.

A February 2013 report by the Transnational Institute warns that the sudden development rush sparked by Burma's political changes has actually fuelled ethnic conflict. The authors estimated that 65 per cent of approved foreign direct investment had been injected into three conflict-ridden states alone: Rakhine, Shan and Kachin. The report states:

'Instability and the lack of effective regulatory mechanisms has provided opportunities for rapacious, large-scale resource extraction, such as mining, hydropower dams and logging, as well as illegal cross-border trading. The impact on local communities has been severe, and the benefits few and far between.'

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Continued fighting causes human rights abuses and health concerns in Burma's non-ceasefire areas

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Lway Poe Ngeal is a Palaung woman who left Burma for better education opportunities in neighbouring Thailand. Now, she works with the Palaung Women's Organization, which advocates for the rights of an ethnic minority community concentrated in northern Shan state.

Palaung civilians have become caught up in the violence between the Burma Army and armed ethnic militias, including the Kachin Independence Army (KIA), the Ta-ang National Liberation Army (TNLA) and the Shan State Army-North (SSA-N). Upon returning from her most recent aid mission in early 2013, Poe Ngeal says there are at least 2,000 internally displaced people (IDPs) from Palaung communities living in five basic camps in northern Shan state near Kachin state. Aid has barely trickled in to these camps. Food and water shortages are common and medicine is difficult to obtain.

'The new IDPs cannot access humanitarian aid. They don't have shelter. They don't have a safe place to stay. They don't have food, water, or medicine too. They don't have anything because they had to run away from their homes suddenly. It is a new life for them. They have to start their lives again.'

Many men have fled or migrated elsewhere in search of work. That means women are taking on increasing responsibilities and bearing the burden of displacement. For many women in the camps, one of the biggest fears is becoming pregnant again.

'Some women tell me that they don't want to get

pregnant, because they don't know when they will have to go on the run again. They don't want to have to flee while pregnant. So they ask us to give them birth control. We try to give things like birth control pills and condoms, but we don't have enough. They don't know that you have to keep taking the pills and they don't know where to get other medicine. So if we give them enough for one month, they just use it for one month, and that's it. So they will get pregnant again.

'One of the women in the camp was heavily pregnant when she had to run away. She suffered a miscarriage on the journey. Pregnant women have to stay in a safe place and not have anything to worry about except to take care of their own health. But she couldn't do that. Then even after she miscarried, she still had to run.'

Increasingly, some Palaung farmers have had to turn to opium cultivation to survive. The increasing availability of narcotics has sparked an addiction problem. Poe Ngeal has seen the effects in the camps.

'One of the fathers is a drug user. His wife has to starve because of it. Her husband doesn't care about anything; he just cares about drugs. So when they fled from the fighting, she was pregnant. She gave birth to her baby after arriving in the camp. After, the family didn't have anything to eat. Eventually, her husband took the baby and sold it. He trafficked the baby. It's such a horrible story. We don't know how we can help them. We can only support them with small humanitarian aid, but we can't help everyone.'

Burma's president, Thein Sein, has received international attention because of the country's recent political reforms. But Poe Ngeal worries that these cautious changes have overshadowed the continuing humanitarian crisis in conflict zones.

'There are still serious human rights violations in Palaung areas. You see the IDPs running away from their homeland. So how can they survive and live their lives? If the political situation is not stable, they cannot go back to their homeland. They cannot survive. That is very worrying for me.' ■

Cambodia

The issue of land rights dominated concerns for indigenous peoples in Cambodia during 2012. An escalation in controversial economic land concessions, or ELCs, continued to exert pressure on marginalized communities throughout the country, especially indigenous groups relying on ancestral and communal lands for their livelihoods. At the same time, the government's overt support of private firms, often run by individuals with close ties to the ruling Cambodian People's Party (CPP), contributed to what local rights group called the 'worst year' on record for activists trying to defend their land.

A study by local rights group Licadho reported that authorities had carved up nearly one-quarter of the country's land mass as ELCs awarded to private interests. Of these, at least 98 concessions, totalling more than 700,000 hectares, affect land that indigenous communities live on or use, according to a September 2012 report from Surya Subedi, the UN Special Rapporteur on the situation of human rights in Cambodia. The government says ELCs are a vital part of its strategy to develop what is a largely rural-based country, but critics say the policy has seen hundreds of thousands of Cambodians threatened by eviction in the last decade. The roots of Cambodia's land problems can be traced back to the Khmer Rouge, who abolished private ownership and monetary currency during their disastrous rule from 1975 to 1979.

The country held nationwide commune elections in June 2012, which were dominated by the ruling CPP. Before this, Prime Minister Hun Sen announced a moratorium on the granting of ELCs, as well as a new land-titling scheme nationwide. But critics say the programme has been too secretive, while others have speculated that it was more likely part of electioneering in the lead-up to the commune elections, or the general elections planned for July 2013.

While Cambodia's land problems have affected a broad cross-section of society, indigenous groups have been particularly impacted by ELCs and the renewed land-titling efforts. The titling scheme is especially of interest to indigenous communities, who have lived for generations on communally run land. But the government titling scheme has favoured individual private

titles rather than communal ones, which has caused division in some communities. By signing on to private titles, some indigenous families have given up the right to traditional land cultivation methods and other cultural traditions on their ancestral lands inside ELCs. The scheme was initially meant to include access to collective communal titles, with the purpose of honouring indigenous groups' traditional ways of living. But the government later decided to delay the granting of collective ownership, according to local media. In early 2013, however, authorities announced a plan to begin mapping the ancestral land belonging to a handful of ethnic Bunong communities seeking collective titles.

An analysis of a proposed agricultural ownership law by Licadho suggests the government intends to encourage communities to abandon traditional shifting methods of cultivation.

While facing pressure on land issues, health statistics for marginalized indigenous communities continue to be cause for concern. For example, births in urban areas of Cambodia are more likely to be attended by a skilled health professional, compared with rural provinces like Monduliri or Ratanakiri, where many indigenous groups reside.

In his report, Subedi, the Special Rapporteur, warned that forced evictions and relocations resulting from land concessions exacerbate an already challenging health situation, in many cases making it harder for indigenous communities to access water, sanitation and basic health services.

Yet divisive resource projects slated for development near indigenous communities seem likely to heighten problems in the near future. Plans for hydropower projects in the Cardamom Mountains could displace roughly 1,000 mostly indigenous people. The Lower Sesan 2, a dam project of Mekong tributaries in northern Cambodia, will also see an estimated 5,000 people resettled.

In April, well-known conservationist Chut Wutty was gunned down while accompanying journalists to a suspected illegal logging site in the Cardamom Mountains. After altering the official explanation of how Wutty died, authorities claimed Wutty was shot and killed by a military

police officer, who was in turn accidentally killed by a private security guard working for a logging company. A provincial court convicted the security guard of causing an accidental death and sentenced him to two years in prison, only to suspend the remaining sentence.

Wutty had become a thorn in the side of the government by shining a spotlight on illegal logging. He also campaigned on behalf of indigenous communities in Prey Lang forest, a lowland evergreen forest in central Cambodia.

Critics saw Wutty's death as a tragic continuation of repeated attempts to intimidate and threaten land rights activists. Throughout the year, activists reported numerous cases where community organizers had been summoned to appear in court to face charges of incitement, or where authorities disrupted rights training sessions. A January 2013 report from the Jesuit Refugee Service focused attention on the under-studied problem of discrimination against Cambodia's Vietnamese minority, which comprises an estimated 5 per cent of the population. Many Vietnamese in Cambodia live in limbo, having been denied the documents required for citizenship, even though many speak the Khmer language and were raised in Cambodia. The report argues that such groups are at risk of statelessness. Being denied basic citizenship rights also makes these already vulnerable groups more susceptible to human trafficking.

Additionally, members of the Khmer Krom minority – ethnic Khmer from southern Vietnam – continued to report difficulties accessing basic services. Though the government's stated policy is to welcome Khmer Krom in Cambodia, advocates for Khmer Krom say they face discrimination in practice.

The Extraordinary Chambers in the Courts of Cambodia, the UN-backed war crimes tribunal set up to try senior leaders of the Khmer Rouge regime, continued its work throughout the year. But it faced increasing questions over the status of future cases and the likelihood of seeing a full trial against its frail and ageing defendants. In March 2013, Ieng Sary, the regime's former foreign minister, died at the age of 87. The court also continues to be dogged by funding shortfalls, which threatened to disrupt proceedings. Despite

its faults, which include serious allegations of political interference, the court's backers see it as a rare symbol of justice following years of impunity for Khmer Rouge perpetrators.

While the court is pursuing crimes committed against the Cambodian people as a whole, the two remaining elderly defendants on trial – the Khmer Rouge regime's chief ideologue, Nuon Chea, and its former head of state, Khieu Samphan – are also charged with genocide specifically against the minority Cham Muslim community and ethnic Vietnamese, who historians believe were both specifically targeted by the regime.

Indonesia

Indonesia, the world's largest Muslim-majority nation, is also an intensely diverse country whose citizens are drawn from an estimated 300 separate ethnic groups, speaking different languages and practising multiple religious faiths. While the country is often held up as a model of religious tolerance and democracy, alarming instances of intolerance, which sometimes spilled into violence, shows that the reality is far removed from the political platitudes.

There were numerous examples throughout the year. Members of Indonesia's Ahmadiyya community, a Muslim community branded heretics by religious conservatives, continued to face persecution. In April, members of fundamentalist group Islamic Defenders Front (FPI) attacked an Ahmadi mosque in Singaparna, West Java, according to the Asian Human Rights Commission (AHRC), which contends that police did little to stop the damage.

That same month, the AHRC says FPI members forced an Ahmadiyya religious leader on Batam Island to sign an agreement to stop holding religious activities. In July, local media reported that 'an angry mob' attacked and injured three Ahmadis in Bogor. Other Ahmadiyya communities continue to be marginalized. Local media reported that 120 members of the Ahmadiyya community remain displaced in West Nusa Tenggara province, seven years after a mob attacked and burned their homes. They are unable to obtain basic identity cards, preventing them from accessing needed health and education services.

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In Cambodia's remote Ratanakkiri province, resource exploitation puts pressure on indigenous communities

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Ploy Them is an ethnic Tampuan woman living in Ratanakkiri province in Cambodia's remote north-east.

In 2004, Them says the government awarded a land concession to a firm that quickly opened up a large gem mining operation. Her fellow villagers were allowed to stay, but some of the gem mine infringed on the local community forest. By the time the company left several years later, the water flowing in a nearby stream had become undrinkable. Today it has an oily sheen and villagers are afraid to bathe or wash their clothes in it. A well provided by an NGO broke down. They now rely on a basic well that villagers dug nearby.

'We don't drink the water any more. We used to wash in the stream, but the water is no good to use now. If the water is not clean, then it's not very good for living. The company was trying to look for gems and they made the water dirty. When people drank the water, they became sick.'

Ratanakkiri is a hotbed of activity for resource exploitation industries. In recent years, large-scale logging, rubber and agro-business plantations and mining operations have opened up as a result of economic land concessions granted by the government. In

Ratanakkiri alone, authorities have issued land concessions to private firms for at least 157,000 hectares of land where indigenous communities live, according to estimates from a September report by the UN Special Rapporteur on human rights in Cambodia. Naturally, these projects cause conflict with local indigenous communities. For example, in early 2013, multiple indigenous communities complained about at least three separate Vietnamese-run rubber firms, according to local media. Complaints included accusations of the bulldozing of community farmland and filling in a lake vital for food and irrigation. Such firms had been granted controversial economic land concessions in the area. Despite the resource development, the province remains one of the most impoverished in the country. Them worries about the health of her six children, because the nearest clinic is at least 15 km away.

'If my family gets sick, the nearest clinic is far away from here. This year, my son got very sick. He couldn't eat anything or even swallow. We spent a lot of money to get there. We had to take loans from other people just to pay for the trip. Now my daughter is sick with diarrhoea. I want to take her to the health clinic, but if we don't have money, what can we do? We just stay here and do what we can.'

Them says that recently a representative from a new company came to the village and showed residents a map of a land concession they planned to develop. Some of the concession overlapped with parts of the community's land. The company has not yet returned, but Them says people in her village are worried about the future.

'We really don't want to lose the land. If we lose the land, we will surely die. We can't live without land to farm. All the villagers want to stop the company because we can't afford to lose our land.' ■

A report by Ahmadiyya advocacy group Lajnah Imaillah, submitted to the UN's Committee on the Elimination of Discrimination against Women (CEDAW) in July, outlined health concerns for a group of displaced Ahmadis who had fled violence from their homes in West Nusa Tenggara province. Some children from a group of 170 people living in temporary shelters on Lombok island were suffering from malnutrition, while others had dropped out of school.

Rights groups also called on authorities to stop attacks against minority Shi'a Muslims. In July, a Shi'a cleric from Madura Island was convicted of blasphemy for his religious teachings. An August incident left one Shi'a man dead in the same community after an attack in which a mob also burned down 35 homes belonging to Shi'a families. By the start of 2013, rights groups said local authorities were threatening the families already displaced by the violence with forced eviction.

Persecution against Christians also continued in parts of Indonesia, with groups blocking some congregations from holding religious services. In April, for example, local officials in an area outside Jakarta obstructed 100 members of the Filadelfia Batak Christian Protestant Church from worshipping. In 2009, local authorities stopped the planned construction of a church there, and the congregation has faced continuous opposition.

Overall, the Jakarta-based Setara Institute for Democracy and Peace recorded 264 cases of violations against religious freedoms during 2012 – a figure that has risen steadily over the last six years.

Rights groups say such persecution against religious minorities continues to occur in part because of a weak government response. For example, authorities have encouraged Christian and Shi'a communities to relocate, while court prosecutions against perpetrators of violent attacks are rare.

In July's CEDAW session examining Indonesia, the country's National Commission on Violence Against Women (Komnas Perempuan) warned that acts of intolerance against religious minorities could see an increase in violence against women in particular. Women from religious minorities face additional threats

of rape and sexual intimidation even after the attacks, while those driven into shelters, as with the Ahmadiyya communities in West Nusa Tenggara, have lost their jobs and been prevented from registering their marriages.

In its concluding statement, the committee expressed deep concern about the pressures faced by rural and indigenous women. Women from rural settings were much less likely to be able to give birth in a health facility than their urban counterparts, a worrying problem that directly affects uneven maternal mortality rates, the committee stated.

Overall, Indonesia has made progress in lowering its maternal mortality rate, from a baseline of 390 deaths per 100,000 live births to 228, according to the government's Millennium Development Goals (MDGs) update last year. The goal is to reach 102 deaths per 100,000 live births in 2015. However, the results are uneven across the vast archipelago, with troubling differences between urban areas and the rural villages where many minority and indigenous women live. The discrepancy can be blamed in part on a weaker health system in outlying areas.

Indonesia's often heavy-handed crackdown on the movement for autonomy and self-governance in West Papua continued to have detrimental impacts on indigenous Papuans in the country's easternmost provinces.

In June, police shot and killed independence activist Mako Tabuni, whose death triggered angry demonstrations. Police claim the vice-chairman of the National Committee for West Papua (KNPB) violently resisted arrest, but activists and rights groups dispute this. Also that month, KNPB leader Buchtar Tabuni was arrested after police accused his organization of engaging in violence.

Throughout 2012, activists and rights groups accused police and military of employing intimidation tactics against activists, including arbitrary arrests, shootings and torture. In a June report, the Commission for Missing Persons and Victims of Violence (Kontras) outlined what it said was a drastic increase in reported torture incidents over the past 12 months, predominantly at the hands of police. The rights group said they had recorded 86 allegations of torture – triple the previous total. Roughly 40 per

cent of reported victims were from the Papuan provinces.

The continuing conflict in West Papua is exacerbating what is already a worrying health situation for civilians. According to Indonesia's National AIDS Commission, AIDS prevalence rates are at least 15 times higher than the national average. This suggests a need to step up awareness and education efforts in high-risk areas. At a national level, heightened HIV infection rates are generally found in traditionally high-risk groups. However, in Papua, health professionals say the problem is more widespread across the general population. At the same time, NGOs, including those working in the health sector, say the authorities have made it increasingly difficult to work in the area, which suggests that West Papua's political stability will be an important determinant in changing health outcomes for minority groups.

Cases of land conflict between private companies and indigenous communities continued through the year. Protesters have often found themselves on the receiving end of excessive police force when staging demonstrations. In February 2012 for example, police shot and injured five farmers in Sumatra's Riau province. The AHRC said the farmers were peacefully protesting against a palm plantation firm.

The national government's broad development plans seem likely to be a source of future conflict if not handled carefully. Indonesia's Economic Master Plan (MP3EI) seeks to stimulate growth through a focus on so-called 'economic corridors' – clustering and connecting industrial and special economic zones throughout the country. It is crucial that indigenous groups themselves are included in any such planning that affects their land and livelihoods; failure to do so could instead increase tensions with affected groups.

In May, Indonesia was subject to scrutiny as part of the UN Human Rights Council's UPR process. Member states urged Indonesia to ensure that perpetrators of assaults against religious minorities were brought to justice and to ensure the rights of indigenous peoples. But some rights groups were disappointed by Indonesia's response to the UPR, which included a passage stating that 'given its demographic composition, Indonesia

... does not recognize the application of the indigenous people concept as defined in the UN Declaration on the Rights of Indigenous Peoples in the country'.

Laos

Laos, a single-party state, nominally allows for freedom of religion, so long as worshippers adhere to one of the state-sanctioned groups within four recognized religions: Bahá'í, Buddhism, Christianity and Islam. Evidence from rights monitors shows authorities continued to harass and repress those who attempted to exercise their rights outside of these parameters, particularly in rural areas.

The US-based Human Rights Watch for Lao Religious Freedom (HRWLRF) highlighted a number of cases throughout the year. In February, for example, HRWLRF says local officials threatened to expel 10 Christian families in northern Laos' Luang Prabang province, unless they renounced their faith. The organization says Lao authorities have cracked down in particular on new Christian converts in Savannakhet province.

A joint 2012 report between the Lao Movement for Human Rights (MLDH) and Paris-based International Federation for Human Rights (FIDH) noted that many Christians in Laos come from already marginalized ethnic minority groups. The report stated, 'Repression against Christians has not diminished and has even intensified in 2012.' The US Commission on International Religious Freedom (USCIRF) listed Laos as a 'watch list' country because of 'serious religious freedom abuses'.

Ethnic diversity in Laos is expansive; officially, the government recognizes 49 separate groups, but there are likely quadruple the number. Rights groups say the Hmong continue to be among the most persecuted, because of Hmong leaders' support of the United States during the Vietnam War. Of particular concern are a group of 4,700 that Thailand forcibly repatriated to Laos in late 2009 – a group that included 158 who had already been granted refugee status before their deportations. Other than a tightly controlled visit in 2010, neither rights monitors nor aid workers have been granted access to the camps where the returned Hmong were held. According



Above: Hmong boy at a market in Laos. *Chris Stowers/Panos.*

to the MLDH, ‘repatriated Hmong have been victims of imprisonment, re-education and discrimination’.

Unanswered questions also remain about prisoners detained in Vientiane’s Somsanga drug detention centre – ostensibly a facility for treating drug addiction that critics say is more of a prison for undesirables. HRW researchers say there is evidence that Hmong have been detained there.

Landmines or other unexploded ordnance (UXO) still kill or injure about 100 people each year in Laos, one of the most heavily bombed countries on earth. The government itself acknowledges that assistance to landmine and UXO survivors is ‘still inadequate’. As the International Campaign to Ban Landmines notes, ‘Most survivors come from the poorer remote areas, belong to ethnic minorities, and are disproportionately disadvantaged by the existing limitations in the provision of service.’

This is representative of Laos’s overall struggle to bring adequate health care to remote communities, where many minority groups live. A World Health Organization (WHO) profile of the health sector noted that the government claims 93 per cent of the population lives within an average walk of 90 minutes to the closest health facility, but there are ‘major differences’ in accessibility compounded by ethnicity and gender.

A separate WHO/Ministry of Health report on the mental health system noted a large gap in the distribution of health professionals between urban and rural settings. All the country’s psychiatric treatment centres are located in the capital, Vientiane, rendering it highly prohibitive for ethnic minorities living in the highlands to access them. The report concluded, ‘Inequity of access to mental health services for other minority users ... is a major issue in the country.’

A study published in the *Asia-Pacific Journal of Public Health* in November examined health inequalities in the country. The authors found

highland Mon-Khmer minorities reported 'significantly worse health, even after making adjustments for their living in inaccessible areas'.⁹ While the government is attempting to reduce the geographic inequalities in the health system, the results have been slow in some cases. For example, a July news report from Inter Press Service (IPS) showed that many rural minorities were unaware of a new mobile midwife programme – a year after health authorities had launched it.

Land issues in the country continued to place pressure on minority communities. In a January report submitted to the UN Committee on the Elimination of Racial Discrimination (CERD), the Unrepresented Nations and Peoples Organization (UNPO) warned that land concessions for rubber plantations were stripping Hmong people of their land with inadequate compensation.

During 2012, Laos broke ground on its controversial Xayaburi hydropower dam. The 1,285 megawatt dam would be the first project on the mainstream of the Lower Mekong River and have adverse effects for the food supply downstream. About 2,000 people around the area are expected to be displaced – a number that includes many indigenous Lao Theung families. Conservationists say the project, and others planned on the Mekong, could decrease fish supplies and have a major impact on food security in the future.

In December, prominent human rights activist Sombath Somphone went missing. Supporters believe Sombath was abducted. The government has denied involvement, but international rights groups and diplomats have expressed grave concern.

Malaysia

In Malaysia, controversial new legislation drew broad criticism from rights groups at home and abroad. The Peaceful Assembly Act was passed in late 2011. Critics, including civil society groups and the political opponents of Prime Minister Najib Razak, said the law's 'excessive restrictions' would be used by the government to crack down on public demonstrations, rather than support freedom of assembly rights.

In April, the anti-corruption coalition, Bersih,

staged a large-scale rally in Kuala Lumpur. Organizers claimed up to 300,000 people attended. As in previous Bersih protests, police responded in a harsh manner, arresting hundreds. In June, three UN special rapporteurs issued a statement urging the government to protect activists from harassment, drawing attention to claims of intimidation against Bersih organizer Ambiga Sreenevasan.

During 2012, parliament approved legislation to replace the Internal Security Act, which had been used to harass government critics in previous years. But its replacement, the Security Offences (Special Measures) Act, still allows those suspected of 'security offences' to be detained without trial. The new legislation, Amnesty International stated, 'merely replaces one oppressive regime with another'. In multicultural Malaysia, the issues of ethnicity and religion are never far from the surface. Islam is the majority religion, with significant Buddhist, Christian and Hindu minorities. In June, JAIPP, the Islamic affairs council in Penang, investigated after Christians were accused of proselytizing to Muslims. No evidence was found of this, according to rights group Suara Rakyat Malaysia, or Suaram, but the issue nonetheless highlighted the sensitivities of religious matters in the country. In October, Suaram said parents at SK Pos Bihai, a school for indigenous children in Kelantan state, accused a Muslim teacher of slapping their non-Muslim children because they could not recite an Islamic prayer. Government officials initially denied the claims.

Peninsular Malaysia's diverse indigenous peoples, collectively known as Orang Asli, comprise less than 1 per cent of the overall population, yet face worrying health discrepancies. For example, a report by the Women's Aid Organisation (WAO) examined Malaysia's progress on gender equality. It pointed out that studies show Orang Asli women have a lower life expectancy than men. They also run a greater risk of malnutrition and have high rates of postpartum haemorrhage and puerperal sepsis. As researcher Colin Nicholas of the Center for Orang Asli Concerns has noted, 'With the majority of them living below the poverty line, their narrow margin of survival makes the Orang Asli's health situation precarious.'

Orang Asli communities also find themselves battling over land and development in their often resource-rich areas. Early in the year, 13 Temiar protesters in Kelantan were arrested after they protested against an agricultural project slated for development on their ancestral lands, according to rights organization Aliran Kesedaran Negara. Activists in the area have also warned of the increased threat posed by rubber plantations.

In Borneo's Sarawak, extensive plans for massive hydropower projects are of major concern to indigenous communities. The first such project, the Bakun dam, was responsible for the forced displacement of 10,000 indigenous people before it was finished in 2011. Now, activists are fighting against the next projects in line – the Murum and Baram hydropower dams, which rights groups say could displace more than 20,000 indigenous people altogether.

In October, 450 Orang Ulu villagers – a general name used to describe several tribes on Sarawak – protested against local leaders who they said had pledged support for the Baram project without their consent. In September, villagers at risk of losing their homes blockaded construction of the Murum dam, which was expected to be completed in 2013. A September report from the Forest Peoples Programme noted that the expansion of palm oil plantations in Sarawak is proceeding at a rate of 90,000 hectares each year.

The WAO report also highlighted the abuse of Penan women and girls in Sarawak. The report included allegations of abuse at the hands of timber workers, underscoring the interconnection between resource-exploitation without sufficient local consultation and human rights problems. An April briefing by the Global Health Group said Malaysia should focus its anti-malaria fight in part on Borneo, where indigenous populations remain at high risk. The government has set a goal of eliminating malaria on peninsular Malaysia by 2015; however, the deadline is five years later on Malaysian Borneo. The malaria issue for indigenous peoples in Sarawak and Sabah is indicative of unequal access to vital services. While the usage of ineffective traditional remedies and environmental factors contribute to the problem, indigenous peoples on Malaysian Borneo also lack the same access to health care as

the population as a whole.

Ethnicity remains a hot-button issue in Malaysia, particularly in the lead-up to planned elections in 2013. Analysts say ethnic Chinese voters are becoming increasingly disillusioned with Razak's ruling coalition, with public opinion surveys suggesting an increasing lack of support. This may have ramifications for ethnic minorities in general, should the coalition decide to shore up its support by instead focusing on policies popular with majority ethnic Malays. Already in 2012, minority politicians complained of veiled threats of violence.

Meanwhile, China continued to show that it had the ability to export its domestic agenda to neighbouring countries in its pursuit of minority Uighurs. Radio Free Asia (RFA) reported that 11 Uighurs whom Malaysia previously repatriated to China had been sentenced to prison terms in China on charges of 'separatism'. At the end of the year, Malaysia again bowed to China's wishes, forcibly returning six Uighurs with pending asylum claims. HRW called it 'a grave violation of international law'.

The Philippines

The year 2012 in the Philippines was bookended by a pair of natural disasters that shone a spotlight on the hardships faced by minority and indigenous groups – already marginalized populations that suffered from an uneven disaster response in the aftermath of the damage. Tropical Storm Washi, known as Sendong in the Philippines, slammed into Mindanao in mid-December 2011 before touching down in Palawan. Both areas have a significant population of minorities or indigenous peoples. The storm killed more than 1,200 people and left 300,000 homeless – one of the Philippines' worst natural disasters in years. In February 2012, more than a month after the storm hit, UNICEF reported an alarming rise in child malnutrition rates attributable to the storm's effects.

One year later, a report on Sendong's effects by the Internal Displacement Monitoring Centre (IDMC) warned of an uneven response to survivors in places like Northern Mindanao's Cagayan de Oro. Some respondents told researchers that authorities had classified them as migrants rather than Sendong survivors,

preventing them from accessing aid. The January 2013 report stated, 'Evidence suggests that Sendong survivors in Cagayan de Oro have not received equal treatment on the basis of their political opinion or ethnic or social origins.' In surveys of affected areas, there were anecdotal reports of gender-based violence and coerced prostitution at relocation sites. This suggests an urgent need to study and address this issue as part of future planning for disaster response.

In December 2012, Typhoon Bopha, known as Pablo in the Philippines, struck Mindanao, killing more than 1,100 people and displacing hundreds of thousands. Again, medical experts raised concerns of lingering health impacts, particularly in areas where the storm had destroyed local health clinics and severely damaged larger hospitals.

However, disaster response experts applauded the government in February 2013 for introducing the Act Protecting the Rights of Internally Displaced Persons. The IDMC called it 'the first of its kind in Asia', particularly for highlighting the rights of indigenous peoples and women.

While this may be a positive development, throughout the year alarming acts of violence against indigenous people, often land rights activists and their supporters, continued to tarnish the Philippines' human rights record. In March, Lumad leader Jimmy Liguyon was shot to death, allegedly at the hands of a paramilitary group, according to Kalipunan ng mga Katutubong Mamamayan ng Pilipinas (KAMP) – an alliance of indigenous peoples' groups. In July, Willem Geertman, a Dutch missionary who advocated on behalf of indigenous peoples in Central Luzon, was shot dead in front of his office, KAMP stated. In September, the AHRC reported that the son of a tribal leader opposed to local mining operations was shot on his way to school in Zamboanga del Sur in western Mindanao. In October, Gilbert Paborada was shot dead in front of his home in Cagayan de Oro. Paborada led an advocacy organization that opposed plans for a local palm oil plantation.

The reported violence against indigenous activists often went hand in hand with land disputes, primarily over private development projects opposed by local communities in resource-rich areas. For example, KAMP linked

the May shooting death of Margarito Cabal to his opposition to the controversial Pulangi V hydropower dam in Mindanao. Groups like KAMP point the finger at the government of President Benigno Aquino III or its agents. In October, KAMP claimed there had been 30 extra-judicial killings of indigenous activists or their supporters in the 28 months since Aquino had taken office. In a May statement, the UN's Special Rapporteur on the rights of indigenous peoples, James Anaya, urged South East Asian governments, including the Philippines, not to 'sideline' the rights of groups 'who derive their livelihoods, traditions and ways of life directly from their natural environments'. He highlighted the case of the bio-ethanol energy project in Isabella province, which has displaced indigenous farmers.

Sadly, the killings continued even after year's end. In February 2013, Dexter Condez was killed while on his way home from a meeting about land rights: Condez was youth leader and spokesperson for the Atis, an indigenous community living on the island of Boracay, a fast-developing tourist destination. In 2011, the government had granted the Atis a certificate of ancestral land title to a 2.1-hectare waterfront site. This decision has been challenged by property developers, and the Atis remain severely marginalized.

Since coming to power, Aquino has largely staked his legacy on a peaceful resolution to the long-standing conflict in Mindanao. Violence between the Philippine Army and pro-independence groups, most notably the Moro Islamic Liberation Front (MILF), has had severe effects on civilians over the course of a more than four-decade conflict. In its year-end report, human rights watchdog Karapatan said the military continues to falsely accuse some civilians caught in the violence of being 'Muslim terrorists'.

In October the government and MILF reached a deal the Aquino administration touted as a roadmap to peace. The deal sees MILF dropping its demands for outright independence, in favour of an 'autonomous political entity' to be known as Bangsamoro. This represents a hopeful step towards ending the violence in troubled Mindanao. However, much work



remains to be done to ensure a lasting peace in the lead-up to 2016 and beyond, when the framework agreement calls for the election of the Bangsamoro legislature and the formation of a government. A disarmament plan must still be agreed upon and implemented, as must a method of ensuring that the rights of non-Moro minorities are respected. At the same time, not everyone is on the same page. Militant group Abu Sayyaf remains on the sidelines, as does the Bangsamoro Islamic Freedom Movement, a MILF breakaway group that, in August, clashed with the army in the lead-up to the peace accord, causing the temporary displacement of an estimated 60,000 civilians, according to the IDMC. To its credit, the framework agreement includes passages – albeit brief ones – calling on parties to respect the ‘customary rights and traditions’ of the region’s indigenous peoples.

While the peace process is welcome, it does not negate the years of significant suffering by civilians. In February 2012, the World Bank and World Food Program released a general population survey of central Mindanao, which highlighted the far-reaching effects of the conflict.

The report estimated that 40 per cent of families in the survey areas had been displaced by fighting at least once between 2000 and 2010. Compared to Christians in the survey area,

there were four times as many Muslims exposed to unprotected water sources, while Muslims also had to travel double the distance to access health clinics or schools, according to the report. Previous studies have noted that when displaced Muslims seek shelter in Christian communities women often face the bulk of discrimination, as many are easily identifiable if they wear headscarves. At the same time, key health statistics in the Autonomous Region in Muslim Mindanao (ARMM) are troubling. The ARMM has the highest levels of under-five, infant and neonatal mortality of all 17 regions, according to a January 2013 study on health inequality in the Philippines. In Northern Mindanao, under-five and neonatal mortality rates actually increased between 2000 and 2007.

In late December, the Philippines took a major step when President Aquino supported legislation that would make it easier for women to obtain contraceptives and would make sex education mandatory in public schools. The issue was a divisive one in a country where the Catholic Church holds significant influence. However, abortion remains illegal in the Philippines. During the UN’s UPR for the Philippines in May, the Committee on Economic, Social and Cultural Rights (CESCR) urged the government to address the issue of maternal deaths stemming from unsafe abortions by ‘reviewing’

Left: Karen people from Burma work in fields in Mae Sot, Thailand. *William Daniels/Panos.*

its legislation on abortions. Sweden urged the Philippines to amend legislation to allow for abortion in cases of rape, incest or when the health of a pregnant woman is threatened.

Thailand

The unresolved conflict in Thailand's south continued to be a source of instability and human rights abuses throughout 2012. While Thailand is predominantly Buddhist, its southern border provinces are home to a majority Malay Muslim population. A separatist insurgency – and the often-criticized response from Thai security forces – continued to see civilians caught in the middle and even targeted. Since 2004, more than 5,000 people have been killed.

In February, a truck bomb explosion in front of a public health office killed a retired teacher and injured 13 other civilians. One month later, a roadside bomb struck down four soldiers. Also in March, nine people were killed and a further 70 injured after a series of bomb explosions, which authorities blamed on separatists. Insurgents also continued attacks on public sector civilians. This included a December attack in which insurgents allegedly shot dead two ethnic Thai Buddhist teachers. Some insurgent fighters view civilians such as teachers and civil servants as legitimate targets because they are perceived to represent the Thai government. HRW counted 11 separate attacks on schools or teachers in the preceding month and a half before the December killings.

Civilians have also been victims of violence perpetrated by the army. In January, for example, Thai troops killed four people initially identified as insurgents. But the military later admitted the four were not linked to the separatist movement. Critics say the military has targeted innocent Muslim civilians suspected of being insurgents with insufficient evidence. In submissions to the UN CERD, a coalition of advocacy groups based in the south said 80 per cent of arrests made following insurgent attacks were based on false assumptions or accusations from a third party. The coalition – the Alliance for CERD Alternative Report on Racial Discrimination

towards Malayu in Southern Border Provinces of Thailand (ACARM) – claimed that state discrimination against Malay Muslims has 'created an environment of distrust' between authorities and the local affected communities. ACARM highlighted problems for Malay Muslims in accessing health care. These include communication problems for elderly Muslims in public hospitals and the failure of some health care centres to accommodate Muslim customs. ACARM also says Malay Muslim women have been disproportionately affected by the Thai military's response to the conflict, shouldering the responsibilities for providing for their households if male family members are killed or arrested.

Thailand is home to diverse ethnic minority communities, particularly in its northern hill areas. In its CERD submissions, the Coalition on Racial Discrimination Watch (CRDW) highlighted problems of racial discrimination. For example, reports in local media that ethnic minority communities had cut down trees propagated the view that such groups were responsible for the destruction of forest areas. Indigenous peoples in forest areas have become 'scapegoats' for climate change, CRDW argued, citing an Environment Ministry practice that fines forest-dwelling communities like ethnic Karen or Hmong for practising shifting agriculture techniques.

The report noted that there were still more than 100,000 indigenous people who had no access to the public health system. A significant problem is many indigenous people's inability to obtain legal status. NGOs who work with such communities say that applicants suffer from a lack of information on procedure. While the government allows in-process applicants to receive health care, the National Commission on Human Rights of Thailand notes, 'public health services are still elusive for hill peoples who have not yet received status'. In its concluding observations from an August session, the CERD stated:

'The Committee is concerned about the inadequate access to social welfare and public services by certain ethnic groups because of language barriers and the limited availability of such services where these groups live.'

Thailand has long been home to tens of thousands of refugees who have fled fighting in eastern Burma. Though Burma has struck fragile ceasefires with some armed ethnic militias, the situation remains volatile. Along Thailand's western border, more than 150,000 people, both registered and unregistered, make their homes in what have become semi-permanent refugee camps. In the past, Thai officials have publicly mused about sending refugees back to Burma as the country opens up.

In a July visit to both countries, the UN High Commissioner for Refugees, António Guterres, said it is imperative that the refugees not be forced to return, particularly while the situation across the border remains uncertain. But life in and out of the refugee camps in Thailand remains tenuous. Refugees staying within the camps are not allowed to work. Those who try to make a living outside the camps are often without status and at risk of deportation. A September report by HRW, meanwhile, said that dwindling funds mean health organizations are struggling to provide adequate assistance in the camps. One French NGO downsized its outreach staff and cut its mental health services by 40 per cent. Camps have also lost skilled refugee health workers and teachers to resettlement, resulting in less experienced replacements and, noted one NGO official, 'a decline in services'. The HRW report states, 'With a reduced support network and fewer coping skills and after so many years with restrictions on movement, proscriptions on the right to work, and dependency on outside aid, many camp residents experience domestic abuse, depression, and other social and mental health problems.'

Vietnam

Vietnam's Constitution nominally allows for freedom of belief and religion, but only 'lawful religious organizations' are protected by law. Sanctioned religions include Buddhism, Cao Dai, Catholicism, Hoa Hao, Islam and Protestantism. Followers of religious denominations that do not enjoy official status faced particular problems throughout the year.

In June, authorities demolished two Christian churches built by ethnic Hmong in Dien Bien province. One of the churches belonged to an

unregistered church group, the Vietnam Good News Mission, while according to UNPO, the other belonged to the registered Evangelical Church of Vietnam (North). In early January 2013, authorities began tearing down a monastery in Hanoi, according to Asianews.it, a Catholic news website.

In late December, Vietnamese police arrested Le Quoc Quan, a Catholic lawyer who was an outspoken advocate for democracy and freedom of religion. In August, police conducted a mass raid on Degar Christians in Kontum, a highland province. According to the Degar Foundation, more than 30 mostly elderly people were injured when they could not disperse quickly enough. In November, the group reported that police arrested six Degar Christians in a separate raid. Degar refers to the indigenous peoples of the central highlands, who were called Montagnards by the former French colonial administration.

Buddhist orders not sanctioned by the government also faced harassment. In June, police beat a monk from the outlawed Unified Buddhist Church of Vietnam, after arresting him for not wearing a helmet while driving a motorbike, according to RFA. The US Ambassador to Vietnam, David Shear, later met with the leader of the church in an apparent show of support.

But the US's own stance on Vietnam's treatment of religious minorities is mixed. During 2012, the USCIRF once again recommended that Vietnam be designated as a 'country of particular concern' (CPC) by the US State Department – countries that display severe violations of religious rights, which could then be subject to US government sanctions. But Vietnam has not been included on the State Department's final CPC list since 2006. Some observers have attributed this discrepancy to the United States' renewed strategic interests in Asia, which include a warmer relationship with Vietnam.

A controversial new government decree on religion approved in late 2012 may see the situation worsen for religious minorities. Decree 92 include new requirements to obtain legal status, including a provision stipulating that applicants must not previously have 'infringed

on national security'. Such broad wording seems likely to increase the ways in which authorities can crack down on unsanctioned groups.

Meanwhile, freedom of expression continued to be tightly controlled during the year. According to the Committee to Protect Journalists, Vietnam had locked up 14 journalists by December. These included journalists who reported on religious minorities and other sensitive topics.

Land conflicts continued to be a contentious issue through the year. In July, authorities jailed three activists who were outspoken about land issues. Land in Vietnam is owned by the state, which grants usage rights to individuals. For Vietnam's indigenous peoples in particular, uncertainty over land-ownership is a pressing concern.

Vietnam is in the early stages of preparing for REDD – Reduced Emissions from Deforestation and Forest Degradation, the UN-backed initiative that applies financial incentives to preserve forest areas. But with uncertain tenure rights, this has the potential to be a future flashpoint. A 2012 briefing paper by the Asia Indigenous Peoples Pact (AIPP) warned that pilot projects in Vietnam showed that much work remains to be done to ensure that indigenous peoples are properly included in meaningful consultation. A 2012 study by a local NGO, Culture Identity and Resources Use Management, noted a wide gap between rights in Vietnam's forestry laws, and the reality for indigenous peoples on the ground.

As part of its submission to the UN CERD, which reviewed Vietnam in 2012, UNPO warned that land disputes are seeing indigenous communities literally losing ground to Kinh people, who form Vietnam's ethnic majority:

'Indigenous groups ... report that large tracts of fertile farms and valuable forest lands have been confiscated and reallocated to ethnic Kinh without fair compensation. In many instances, the indigenous families are relocated to areas that lack access to basic infrastructure and services, including schools and healthcare facilities.'

Health outcomes among ethnic minority and indigenous groups are continually lower than those of the general population. In the Khmer

Krom community – ethnic Khmer who live in southern Vietnam – accessing basic health care can be problematic. In its CERD submission, the Khmers Kampuchea-Krom Federation (KKF) said many Khmer Krom have difficulty accessing government-subsidized health care and are treated as 'second-class citizens' even when they are able to.

In its CERD submission, the Vietnam Committee on Human Rights (VCHR) said the introduction of user fees for health care two decades ago has led to 'alarming disparities' between ethnic minorities and the overall population. These include significant differences in infant mortality and poverty rates. And a WHO bulletin from December 2012 warned of 'increasing ethnic inequity' in maternal health care in Vietnam. While women in Vietnam were more likely than in past years to receive proper antenatal care and give birth in a health facility, ethnic minority women were at greater risk of not receiving such treatment. The WHO stated that:

'Inequity in maternal health care utilization has increased progressively in Viet Nam, primarily along ethnic lines, and vulnerable groups in the country are at risk of being left behind. Health-care decision-makers should target these groups through affirmative action and culturally sensitive interventions.'

In its concluding observations on Vietnam, the UN CERD said it is 'deeply concerned at the sizeable socio-economic gap between disadvantaged ethnic minorities and the majority Kinh, even when they live in the same mountain area'. For many marginalized communities in remote locations, this economic gap compounds the inequality in accessing health care. Anand Grover, the UN's Special Rapporteur on the right to health, noted in a July report on Vietnam:

'The poor and near poor, especially those in rural and mountainous areas predominantly populated by ethnic minorities, are often burdened by additional expenditures on food, travel and accommodation in order to access basic health services. In many instances, these expenditures amount to more than the cost of the health services sought.'

East Asia

Emily Hong

China

Despite China's once-in-a-decade leadership transition, political developments and legal reforms in 2012 failed to signal a departure from long-standing policies towards minorities and indigenous peoples. The lead-up to the transition was marked by a crackdown in which over 130 human rights activists were detained or faced restrictions between September and November. During the week of the National Party Congress, 11 Tibetans set themselves on fire, reflecting a sense of desperation for political change in Tibet.

On 15 November, the Chinese Communist Party unveiled its new leadership, including Party Secretary Xi Jinping and six others, notably excluding two senior reformist members. Unlike the last grouping, the majority of new Politburo members have coastal constituencies, prompting concern that they may have even less reason to tackle ethnic issues in inland China. Xi became the country's president in March 2013.

In a speech following the congress, Xi only mentioned 'ethnic groups' as part of a narrative celebrating the Party's transformation of 'the impoverished and backward Old China into the New China that has become prosperous'. China's leaders continue to emphasize ethnic unity and modernization but have failed to address the grievances of the country's ethnic minorities, who comprise 8.5 per cent of the population.

In May 2012, the dramatic escape of blind disability rights activist Chen Guangcheng brought China's human rights issues to world headlines. Chinese and international NGOs highlighted his case in September when China participated in its first-ever review under the UN Convention on the Rights of Persons with Disabilities, which it adopted in 2008.

The UN Committee on the Rights of Persons with Disabilities criticized the then draft mental health act for violating the free and informed consent of the individual. The new mental health law was passed in October and prompted mixed responses from human rights groups. According

to Chinese Human Rights Defenders (CHRD), the law marks a 'step in the right direction', but fails to close loopholes allowing police and government officials to commit political dissidents to psychiatric institutions against their will. The year 2012 also saw major reforms in China's Criminal Procedure Law, a process that has been ongoing for almost ten years. The Danish Institute for Human Rights argues that the law has created a 'two track criminal system', representing progress in areas of procedural rights and a ban on torture, but only for 'ordinary criminals'. The legislation simultaneously legalizes the detention without charge of those suspected of terrorism, corruption or jeopardizing national security, charges often brought against Tibetan, Uighur and other minority dissidents. However, controversial 'disappearance' clauses (which would have allowed authorities to detain suspects without family notification) were removed due to overwhelming criticism, according to the *Dai Hua* human rights journal.

The government continued to crack down on activists in China's ethnic autonomous regions. The government intensified its crackdown in Tibetan regions after a record number of self-immolations by Tibetans, reflecting a wider trend in heightened surveillance and repression since protests in 2008. Eighty-two Tibetans self-immolated in 2012; self-immolations continued in 2013. The government opened fire on Tibetan protesters in January 2012, and those involved in self-immolation-related protests have received sentences of up to 13 years. In February 2013, repression intensified with authorities detaining 70 'criminal suspects' linked to 'inciting' acts of self-immolation.

Environmental degradation linked to natural resource extraction in Tibet came to the forefront in April 2013, with a deadly mine-related landslide killing 83 in the Gyama Valley near Lhasa. The Gyama mine, along with other major development projects, is part of the government's five-year plan to make Tibet a mining centre and hydropower engine of China.

Amnesty International highlighted the cases of several Uighur political prisoners, including a famous writer who died in prison due to ill health in 2012. Another prisoner remains critically ill with cancer. Amnesty International

also reported on new testimony which shows that hundreds of Uighurs disappeared during the Urumqi riots of 2009, many of whom are still missing. This is part of wider repression in the Xinjiang Uighur Autonomous Region, as indicated by the alarming number of Uighurs on trial for ‘endangering state security’. Uighurs, who account for less than 1 per cent of the population in China, comprise about half of all those on trial for endangering state security, according to *Dai Hua* journal.

In Inner Mongolia the Southern Mongolian Human Rights Information Center celebrated the news that, after years of efforts by activists, the regional government has agreed to consider a proposal to bring in new legislation to promote the use of the Mongolian language in 2013.

In November, local NGOs Green Sina and Green Earth Volunteers found evidence that toxic water from a coal-processing factory was being illicitly dumped in the Tengger desert of Inner Mongolia, contaminating the underground water and endangering herders in the area.

China’s socialist health care system was once lauded by the World Health Organization (WHO) as an example for other developing countries, with ‘Barefoot doctors’ (*chijiao yisheng*) providing basic services to some of the most rural ethnic areas.¹⁰ Market reforms of health care since the 1980s led to widespread public discontent over the lack of affordable health care. In response, the Chinese government launched major health reforms in 2009, with a goal of achieving universal health coverage by 2020. More than 95 per cent of the population is now covered by some public health insurance, but patients still have to pay for at least 60 per cent of out-patient costs and 50 per cent of in-patient costs, according to a 2012 review published in *The Lancet* medical journal.¹¹ Critics argue that without a focus on structural causes of discrimination, such reforms will have uneven impacts.

China is ‘on track’ towards meeting all of its health-related Millennium Development Goals, but given the lack of data disaggregated for minorities, it is doubtful that national statistics are representative of remote ethnic areas, which often lack basic health infrastructure.

Rural migrant workers living in urban areas,

.....
Case study by *Rinnai Ngadan*
.....

Maternal deaths remain high for China’s ethnic minorities

.....

Many minority women in western China do not give birth in hospitals because of poor-quality facilities and culturally insensitive care.

Despite China’s national progress in the areas of maternal and infant health, rural and ethnic minority regions lag behind. A 2010 UN report tracing China’s progress towards the Millennium Development Goals shows that maternal mortality rates are almost twice as high in western regions, where many ethnic minorities live, than in wealthier eastern provinces.

Since 2000, China has campaigned for all women to give birth in hospitals, in an effort to reduce the number of mother and newborn deaths. And yet such a policy focus ignores two persistent realities that hinder maternal and child health for rural minority women – lower-quality care in rural hospitals and a lack of understanding of traditional birthing practices.

Studies show that ethnic minority women are much less likely to seek health care or give birth in hospitals than the majority Han population. A major study in 2007 investigated the challenges of using maternal health care services for Yi and Mong ethnic minority women in a remote area of south-west China’s Sichuan province.

The study found that accessibility, while clearly a factor given the lack of good roads and transport, was not as important as many presume.

Hospital deliveries are very expensive. The government’s new cooperation insurance

Case study continued

scheme was introduced in the area in 2006, and although most women have paid their contributions, many do not know how to use the scheme. Furthermore, costs of a hospital birth – including medication, transportation and family accommodation – exceed any reimbursement available through the scheme.

Women are also staying at home because of the poor quality of care in township hospitals, where medical staff cannot perform caesarean sections or keep safe blood supplies.

Lack of understanding of local culture and beliefs among health care staff is another important and neglected barrier. The cultural inappropriateness of birthing practices causes women discomfort and embarrassment; and there is a lack of incentives such as pain relief during labour.¹²

Researchers noted how women said that they

Below: Yi woman from Yunnan Province, China. *Eric Lafforgue.*

would prefer not to be shaved, to be allowed to walk around during labour and to give birth in a position similar to the traditional semi-sitting position, which was not available as a choice in the hospital.

The focus on western medical approaches to health and childbirth, and the lack of sensitivity to local culture and practices, contributes to the lack of trust and desire for minority women to give birth in a hospital setting. The government also does not support relationships between health staff and experienced traditional midwives.

In spite of China's progress towards health targets, health issues among ethnic minorities continue to be neglected. The government's emphasis on increasing accessibility and improving health infrastructure ignores the much-needed improvement in service quality. Most critically, a bias towards western medicine in hospitals does not give sufficient attention to the potential and role of traditional health practices. ■



including minorities, are denied access to social services and health care under the *hukou* – or household registration system. Most of the estimated 200 million migrants are still registered as rural residents and so are excluded from accessing health insurance, or must pay higher prices for health care they can rarely afford. In December, the government announced it will speed up household registration reform but the details have yet to be revealed.

Japan

Despite Japan's public narrative of racial and cultural homogeneity, the country is home to several minorities. These include the Burakumin, descendants of outcastes during the Tokugawa period, Ainu and Okinawan indigenous peoples, ethnic Korean and Chinese populations, and its 'newest' minorities *nikkeijin*, Latin Americans of Japanese descent who began to return to Japan in the late 1980s. The year 2012 saw several major events for minority rights and health in Japan – its second UPR by the UN Human Rights Council in October and a visit by the Special Rapporteur on the right to health in November.

In an August 2012 report the Japanese NGO Network for the Elimination of Racial Discrimination documented how legal authorities refused to deal with multiple cases of hate speech against minorities on the basis that there is no legal mechanism or law to prohibit such racial discrimination. The report also documents speeches from a handful of elected officials who have publicly remarked upon Japan's status as 'one nation, one language and one ethnicity' and linked economic success to its status as a country of 'one race'. The anti-discrimination network has pointed to the persistent problem of internet-based hate crimes including so-called 'Buraku Lists', which name town wards populated by descendants of the Burakumin community. One boy who discovered his Buraku origins on the internet committed suicide.

In Japan's UPR in October, several NGOs and UN member states underscored the persistence of direct and indirect discrimination against Japan's minorities. The Network for the Elimination of Racial Discrimination expressed concern that the proposed national human rights institution

would not address discrimination against minorities, and called for the government to adopt an anti-discrimination law.

Following December elections, the Liberal Democratic Party announced it will exclude Korean schools attended by third- or fourth-generation North Korean students from tuition subsidies, citing poor political relations between the two countries. Since then, local governments, including the Tokyo municipal government, have followed suit. Schools for children of migrant workers, such as Brazilian and Peruvian schools, have also not received financial support from the government.

Students of Korean schools have also been the target of hate crimes, a trend that has worsened in recent years. The government has failed to respond to violence against girl students, and so schools have changed the design of noticeably Korean school uniforms to less conspicuous styles.

Japan's minorities also face multiple forms of discrimination with regard to health care. Disadvantaged migrants face multiple barriers to accessing health care, particularly emergency, HIV/AIDS and maternal health care. Migrants and asylum-seekers held in detention centres are particularly at a disadvantage. In a 2012 report, the UN High Commissioner for Refugees (UNHCR) asked the government to consider changing its current policy requiring asylum-seekers to pay for medical care up front and wait for later reimbursement.

A 2012 study published in *BMC Public Health* showed that, despite the universal health insurance policies for legal residents, documented Latin American immigrants disproportionately lack health insurance coverage.¹³ A joint report by the Ainu Association of Hokkaido, the Buraku Liberation League Central Women's Division and other NGOs urged the government to provide counsellors who can offer culturally sensitive care for Ainu, Buraku and Korean women who face domestic violence. The minority organizations claimed there is complete failure to ensure the active participation of Buraku, Ainu and Zainichi Korean women in the deliberation, preparation and evaluation of women's policy, including health.

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Case study by *Emily Hong*
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Japan's Burakumin minority hired to clean up after Fukushima

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The nuclear disaster highlights health hazards for the country's marginalized workers.

In November 2012, Anand Grover, the UN Special Rapporteur for health, made a trip to Japan to investigate the right to health in the context of the triple earthquake, tsunami and nuclear disaster that devastated the country in March 2011. His report highlighted the tremendous health risks for nuclear plant workers exposed to high levels of radiation. At a press conference, the Special Rapporteur said, 'I was distressed to learn that there is a practice of employing a large number of contract workers through a layer of sub-contractors'.

Both Amnesty International Switzerland and an investigative documentary produced by European television network Arte have claimed that many of these temporary workers are from Japan's most excluded minority – the Burakumin.

It is difficult to verify how many of the clean-up workers are Burakumin, but one Burakumin worker, temporarily employed at a nuclear plant in Hamaoka, speaks about his recruitment in the Arte documentary. 'The Burakumin, the Japanese Untouchables,' Yoshito Fujita says, 'when I

arrived, I saw that there were many homeless people, like me, working. I realized then that this company recruits in the poorest areas.'

Kazuyuki Iwasa, the first Japanese worker to sue the government for radiation-related illness, 40 years ago – was a Burakumin. Photographer Kenji Higuchi, whose work documents the exploitation of nuclear plant workers, has highlighted Iwasa's case, which was rejected by the government. In a speech on the Fukushima 50, he spoke of Iwasa's tragic case and untimely death: 'Of course his origin had something to do with his job. In our social structure a discrimination creates another discrimination.'

The term 'Burakumin' refers not to a distinct ethnic group but to people living in *Buraku*, areas where many but not all residents are descendants of the outcastes of feudal society during the Edo period. They were given work, such as leatherwork and butchery, considered 'tainted' according to Buddhist and Shinto beliefs. Despite the formal abolition of the caste system in 1871 and special government measures in the 1970s to prevent third parties from searching Buraku ancestry, the Burakumin – who number between 1 and 3 million – remain one of the most excluded and disadvantaged communities in Japan.

Discriminatory attitudes towards Buraku remain deeply ingrained in Japanese society. According to the Buraku Liberation League (BLL), between 10 and 50 per cent of people surveyed in several prefectures do not want relatives to marry a person of Buraku origin and do not want to live in a school district which includes a Buraku area.

The BLL's survey of 12,000 Burakumin women has shown the continued effects of such discrimination on employment opportunities.

Mongolia

Mongolia is one of Asia's fastest-growing economies, but the gaps between urban and rural populations, particularly among ethnic minorities and nomadic communities, continue to grow. A new governing coalition led by the Democratic Party took power in July 2012, replacing the Mongolian People's Party, which has historically

dominated politics in Mongolia. After the elections, Amnesty International called for new legislation to combat discrimination against minorities and marginalized groups, particularly non-Mongolian nationals, who are often targets of discrimination.

In a speech at the UN General Assembly in November, Mongolia's UN Permanent

Between 60 and 70 per cent of women surveyed work in irregular precarious jobs, a number 1.5 to 2 times higher than the average. In a 2012 report on minority women in Japan, the BLL claims that 'difficulty for Buraku women in obtaining stable jobs originates in their educational backgrounds, which leave them no choice but to take seasonal or irregular work'. Such structural discrimination leads some Burakumin to take jobs in some of the most 'dirty, dangerous, and difficult' industries, including the nuclear sector.

According to Yuki Tanaka, a Professor at Hiroshima City University, Japan's poor, including many Burakumin, have difficulty buying into the national health insurance programme because of the high premiums.

A further issue is the practice of subcontracting, which causes lack of accountability. The Fukushima plant is no exception. Plant owner and spokesperson for TEPCO, Yoshiaki Hirasawa, denied ultimate responsibility for the health and safety of temporary workers in an interview with Arte. According to Hirasawa: 'We currently employ three hundred people at the site of Fukushima through subcontractors. In the end, we do not know who is involved or what conditions are proposed for the most dangerous tasks.'

The dearth of public information on workers' health and safety in the ongoing clean-up at Fukushima points to a larger problem – the persistence of intersecting forms of discrimination faced by Japan's most marginalized minorities. ■

Representative highlighted human rights as a priority of the National Action Plan for 2012–16, including abolishing the death penalty and minimizing the negative impact of business on human rights.

Natural resource extraction is a hot political issue in Mongolia, as evident in debates surrounding the parliamentary election and

upcoming presidential election in May 2013. Eighty per cent of the country's exports are minerals; the Oyu Tolgoi copper and gold mine, the largest foreign investment project in Mongolia, is expected to contribute one-third of the country's GDP by 2020.

The National Human Rights Commission of Mongolia highlighted the negative impact of mining on the environment, the health of local people, and nomadic culture and traditions in an October 2010 report. The Chief Commissioner said the 'right to health protection is violated during mining exploration, extraction, and processing and transportation activities'.

Hospitals in mining-affected counties are unable to provide adequate services to residents and migrant workers, and there are a high number of industrial accidents and occupational diseases among those working at mining sites.

Dukha, Mongolia's smallest ethnic minority, have also felt the impacts of mining and loss of access to natural resources. The 200 remaining reindeer herders in Mongolia's north-west have had to abandon pastures due to deforestation and chemical contamination caused by small-scale gold and jade mining. The ban on Dukhas' traditional hunting methods since 2010 has also affected the nutritional diet of herders. In a 2012 United Nations Environment Programme report, one woman expressed concern that Dukha children are smaller than children born in other parts of the country and that pregnant women do not have access to regular medical care.

In the past few years, UN agencies have focused on projects aimed at benefitting the country's ethnic and linguistic minorities. The UN Education, Science and Culture Organization (UNESCO) is working with the government to establish public television and radio channels in minority languages and community radio projects in minority populated areas of four provinces.

UNESCO has also worked with the WHO to improve health and sanitation in rural Mongolia, including areas populated by ethnic and linguistic minorities, by training health care workers, improving basic water facilities and reducing the spread of infectious diseases in rural county hospitals. The UN Population Fund (UNFPA) has provided 'mobile health care' in remote areas



Above: Dukha people in Mongolia. *Hamid Sardar/Corbis.*

in the wake of a *dzud* – severe cold weather – which destroyed the livelihoods of thousands of Mongolian herders in 2010. This has included mental, reproductive and maternal health for women.

South Korea

In 2012, Jasmine Lee became the first naturalized Korean to win a seat in South Korea's National Assembly. This marked an important step towards Koreans coming to terms with an increasingly ethnically diverse society. However, despite the government support for 'multicultural families', official policies towards immigrants remain pro-assimilation in practice.

In January 2012, immigrants and children of immigrants comprised 2.5 per cent of the population. One out of ten marriages in the country are international and the number of naturalized Koreans is projected to reach 200,000

by 2020. This is in addition to the large number of migrants who come to Korea for work, approximately 550,000 in 2011. Demographic shifts have stimulated public debate on questions around ethnicity and the Korean 'nation', in contrast to the dominant nationalist discourse historically focused on 'one blood' present in textbooks just ten years ago.

The government, despite outward encouragement of 'multiculturalism' – such as sponsoring poster campaigns for the *damunhwa gajeong* (multicultural family) in Seoul's subway stations – has not embraced a multicultural ideal. Government-sponsored 'multicultural family support centres' provide courses on Korean language and culture, prompting criticism that such centres aim to assimilate minorities rather than foster multiculturalism. Public sentiment also remains ambivalent. Xenophobic discourse was ignited in August, when a group of protesters gathered at the immigration office calling for the abolition of multicultural policies.

South Korea's UN UPR in October

2012 highlighted both positive and negative developments with regard to discrimination against minorities. The government noted its efforts to 'ensure that marriage immigrants adjust well to society'. It referred specifically to the Multicultural Family Support Act, which includes provisions for health care and education for 'marriage immigrants'.

Several states urged South Korea to improve treatment of migrants and refugees, and provide children of undocumented migrants with health care. NGOs estimate that 17,000 children of undocumented migrant workers have no access to health care. NGOs expressed concern regarding the new Refugee Act, which will be enforced in July 2013. The Advocates for Public Interest Law have noted a lack of any mechanism to assess the dangers a person could face upon return to his/her country of origin and the Korean Bar Association has criticized the 'accelerated' procedures, which they believe could lead to abuse. In 2010, Korea recognized 11 per cent of asylum applicants compared to a global average of 38 per cent.

In July 2012, a New Zealand woman teaching English in South Korea appealed to the UN CERD when she was forced to take a second HIV test within nine months. The government first introduced mandatory HIV testing for foreign teachers in 2007. An article in the *Journal of Korean Law* has claimed that this constitutes racial discrimination since testing is not required for Korean teachers or ethnic Korean non-citizens. Foreign teachers are the only foreign workers still mandated for HIV testing, since reforms in 2010.

Oceania

Jacqui Zalberg

Indigenous peoples and minority communities experience lower standards of health than the majority population all throughout the Oceania region. The health disadvantages experienced by indigenous peoples and minorities can be considered historical in origin, as a direct result of colonization and the introduction of hitherto

unknown European diseases, which brought about the decimation of indigenous populations throughout the region.

However, the perpetuation of disparities in health outcomes today is due to social exclusion and the circumstances of disadvantage in which many indigenous and minority peoples in Oceania find themselves, including high unemployment rates, low educational achievement, low income, lack of access to adequate housing and sanitation, and high levels of incarceration.

Furthermore, indigenous and minority communities throughout the region may have problems in gaining access to quality health care services. Overall, health systems, particularly in small island states, are often weak, due to insufficient numbers of trained health workers, inadequate financing and planning for the health sector, and unreliability in the procurement, supply and distribution of essential drugs. It is an added challenge for health services to reach the small, highly dispersed populations that exist in many Pacific countries.

The lack of adequate services is often further compounded by a lack of culturally appropriate access to services. Indigenous and minority women of the region experience higher rates of maternal and infant mortality and other poor reproductive health outcomes compared to the majority populations.

Fragile environments and the vulnerability of these ecosystems to extreme weather events and the impact of climate change also impacts on the health of the indigenous peoples of the region. For example in December 2012, Cyclone Evan hit Samoa and Fiji, which left both islands heavily damaged and exposed to serious public health risks, including lack of water, sanitation, hygiene and food security.

In 2012, a number of states of the region were considered by relevant international human rights bodies, which made clear reference to the right to health: New Zealand was considered by the UN Committee on Economic, Social and Cultural Rights and the Committee on the Elimination of Discrimination against Women, both of which paid considerable attention to health outcomes of Māori and minority groups in New Zealand. The Committee on the Rights of the

Child considered Australia's report in 2012, and highlighted disparities across a range of indicators for Aboriginal and Torres Strait Islander children, in particular noting particularly the gap in health status between Aboriginal and non-Aboriginal children.

Samoa was considered by the Committee on the Elimination of Discrimination against Women, which noted the high prevalence of violence against women, in particular domestic and sexual violence, and its impact upon women's health. The committee also observed the difficulties women in rural areas experience in gaining access to affordable and appropriate health care in a timely manner, including reproductive and sexual health services. The Special Rapporteur on violence against women visited Papua New Guinea and the Solomon Islands, observing the negative impacts on women's health due to violence in both countries.

Australia

Aboriginal and Torres Strait Islander Australians continue to experience lower levels of access to health services than the general population: in 2006-2010, their age-standardized mortality rate was 1.9 times higher compared with non-indigenous Australians. They are more likely to be hospitalized for most diseases and conditions; to experience disability and reduced quality of life due to ill health; and to die at younger ages than other Australians. Aboriginal and Torres Strait Islanders also suffer a higher burden of emotional distress and possible mental illness than that experienced by the wider community.¹⁴ Aboriginal and Torres Strait Islander women also experience poorer health across all areas compared with non-indigenous women.¹⁵

The issue of health disparity for Aborigines and Torres Strait Islanders first gained focused political attention with the publication of the 2005 *Social Justice Report* by the Australian Human Rights Commission. The report highlighted the vast gap between the health of indigenous and other Australians and called on Australian state and federal governments to commit to achieving Aboriginal and Torres Strait Islander health equality within 25

years. Following the release of the report, 40 of Australia's leading indigenous and non-indigenous health bodies and human rights organizations joined forces to launch the Close the Gap Campaign for Indigenous Health Equality. Now in its seventh year of operation, the two primary objectives of the campaign are: to close the gap in life expectancy within a generation and to halve the gap in mortality rates for indigenous children under the age of 5 within a decade (by 2018).

Importantly, the campaign was accompanied by a commitment of AU\$1.57 billion over four years (2009-13) to tackle the burden of chronic disease. In April 2013 the federal government renewed its commitment for a further three years, pledging AU\$777 million for the period. Although the government releases annual progress reports, there is a paucity of hard data, in part due to the difficulty in measuring outcomes. However, the latest government report indicated that in 2012 the target for under-five mortality was on track to be met in 2013, and that significant progress had been made against the target to halve the gap between indigenous and non-indigenous under-five mortality by 2018.¹⁶

Other important outcomes of the Close the Gap Campaign have been the reform of Australia's indigenous health institutional framework. In particular, the National Aboriginal and Torres Strait Islander Health Equality Council (NATSIEHC) was developed to provide a forum through which the government can work in partnership with the community and the indigenous health sector to implement its Close the Gap initiatives, and in 2012 focused on the development of the National Aboriginal and Torres Strait Islander Health Plan (the Plan). Furthermore, the newly established National Congress of Australia's First Peoples (Congress), has already indicated that health is one of its top priorities. At the end of 2011, the Congress teamed with 11 Aboriginal and Torres Strait Islander health groups to establish the National Health Leadership Forum (NHLF). The NHLF goal is to ensure the active involvement of Aboriginal and Torres Strait Islander communities in health policy at a national level.

The year 2012 was also a significant one for

Aboriginal and Torres Strait Islander people because of the important political momentum gained regarding recognition of their status in the Australian Constitution. Following extensive consultations held throughout 2011, an expert panel – which included indigenous and community leaders, constitutional experts and parliamentarians – reported to the Prime Minister in January 2012.

It recommended that Australians should vote in a referendum to:

- recognize Aboriginal and Torres Strait Islander peoples and to preserve the Australian government's ability to pass laws for the benefit of Aboriginal and Torres Strait Islander peoples;
- ban racial discrimination by government authorities; and
- recognize that Aboriginal and Torres Strait Islander languages were the country's first tongues, while confirming that English is Australia's national language.

Parliament set up a joint select committee on constitutional recognition of Aboriginal and Torres Strait Islander Peoples in November 2012 and has been asked to consult further on the model, and to help to ensure strong cross-party support so that a proposal can be put to the Australian people at a referendum.

The government also released the Human Rights and Anti-Discrimination Bill in 2012, which consolidated Commonwealth laws covering discrimination on the basis of race, sex, disability and age, and added new protections from discrimination on the grounds of sexual orientation and gender identity. It also strengthened protections against workplace discrimination on the basis of other attributes, including religion and political opinion. Delays, however, have meant that the bill has not yet passed into law.

Minorities and migration

The issue of irregular migrants arriving by boat and the processing of asylum seekers remained an issue of national importance, in particular in the lead-up to the September 2013 national elections. In June 2012, two boats sank within a week of each other, each carrying migrants trying to reach Australia by sea. An estimated 100 people died.

This tragedy has been followed by numerous others, with ongoing deaths at sea throughout 2012 by migrants attempting to reach Australia by boat.

Following these incidents, on 28 June 2012 the Australian government appointed an expert panel on asylum seekers which recommended legislative amendments to allow for the transfer of asylum seekers who arrive in Australia by boat to third countries for the processing of their claims for protection. The proposal in effect re-launched Australia's 'Pacific Solution', a policy by which Australia transports asylum seekers to detention centres on small island nations in the Pacific Ocean. On 13 August 2012, the government passed amendments to the Migration Act, followed by legislative instruments designating Nauru and Papua New Guinea as 'regional processing countries'.

In November 2012, a bill to amend the Migration Act to extend this liability to all asylum seekers who arrive by boat, even if they reach the mainland, was introduced into parliament.

Although the Joint Parliamentary Committee on Human Rights found that Australia's offshore processing laws raise 'significant and complex issues' as to their compatibility with human rights and ordered an inquiry into the legislation, offshore processing continued. There remain serious concerns about the health and mental health impacts of prolonged and indefinite immigration detention.

In particular, Nauru and Manus Island pose specific health concerns for possible asylum seekers detained there. Nauru's acting Health Secretary acknowledged that the island would be unable to cope with any mental health issues of detainees. Moreover, in Manus Island there have been reports of a strain of malaria which can kill if left untreated for just one day.

In October 2012 the Australian government put forward the Migration Amendment (Healthcare for Asylum Seekers) Bill for consultation. Civil society organizations have welcomed the bill's proposal to establish an independent health advisory panel of experts to oversee the provision of health care to asylum seekers who are transferred to regional processing countries, including Nauru and Papua New

Guinea. However, the Australian Human Rights Commission has also noted the need for more comprehensive monitoring of health and mental health services across Australia's immigration detention network.

Fiji

Fiji has experienced a long history of tumultuous politics, most recently marked by the 2006 coup which led Frank Bainimarama to seize power as military ruler. The key issue at stake in the coup was the underlying tension concerning the rights of the Indo-Fijian minority against the indigenous majority. Since 2006, Fiji has maintained tense diplomatic relations with neighbouring countries, and at one point had severed diplomatic relations with numerous states in the region.

The year 2012, however, indicated a possible change in political approach. Bainimarama announced the lifting of martial law and the government initiated consultations on a new Constitution. Following the public commitment to call elections by 2014, countries of the region, including Australia and New Zealand, agreed to restore full diplomatic ties with Fiji.

Initially, there appeared to be a genuine process of consultation on a new Fijian Constitution. Internationally renowned constitutional experts were invited to participate in a newly established Constitutional Commission, which was charged with producing a draft Constitution and paving the way for a return to democracy with free elections in 2014. The Commission proclaimed that its guiding principle was to steer Fiji away from the race-based politics of the previous Constitution, which favoured indigenous Fijians over the Indian minority. It was also based on democratic participation, with reportedly more than 7,000 submissions received.

The Commission's draft Constitution was submitted to Bainimarama in December 2012. However after it was presented, police were ordered to seize copies and burnt the printer's proofs. In the first days of the new year, Bainimarama, together with Fiji's President Nailatikau, pronounced that the regime had serious concerns with the draft produced by the Commission and claimed it entrenched ethnic divisions within the country.

The government released a new draft in March 2013 and invited public consultations, but the process was much shorter and less transparent than the original process. The new draft Constitution says nothing about protections for indigenous peoples' land rights, or mechanisms for resolving disputes between land owners and tenants. It also completely scraps the Great Council of Chiefs, the body of indigenous Fijian chiefs, which has left many indigenous Fijians feeling that they are being excluded from decision-making.

The rejection of the Constitutional Commission's draft and the lack of transparency surrounding the redrafting process will bring into question whether promised elections in 2014 will in fact be free and fair, and will be able to resolve the simmering ethnic tensions in the country.

New Zealand

Māori, New Zealand's indigenous people, make up approximately 15.4 per cent of the country's population, with nearly a quarter living in the greater Auckland area. The relationship between the Māori and the New Zealand government is grounded in the Treaty of Waitangi, which contains a powerful expression of the Crown's moral obligations to act honourably in its dealings with Māori.

There are also more than 22 different Pacific communities in New Zealand – each with its own distinctive culture, language, history and health status. Collectively known as Pasifika, the biggest Pacific groups in New Zealand are the Samoan, Cook Islander, Tongan, Niuean, Fijian, Tokelauan, and Tuvaluan communities. To date, the majority of the Pacific communities in New Zealand originate from Polynesian states, however migration to New Zealand from Melanesian states has also increased, and predictions indicate that New Zealand can expect much larger numbers of migrants from Melanesia in the coming decades.

It is also important to note that there has been a rapid increase in the last decade of the number of Asians in New Zealand. By 2001 Asians had displaced the Pasifika communities as the third most populous ethnic group, with the 2006 Census data estimating the Asian population of New Zealand at around 9.2

per cent, with predicted growth to up to 16 per cent of the national population by 2016. Chinese (46 per cent) and Indian (29 per cent) are the majority groups, with populations from other Asian communities including Koreans, Filipinos, Japanese, Sri Lankans, Cambodians and Thais.

Despite significant gains in recent years, Māori continue to have the poorest health of any New Zealand group. Māori have a higher mortality rate than non-Māori, as well as higher rates of illness. Māori infants die more frequently from SIDS (sudden infant death syndrome), have lower birth weight than non-Māori and also experience higher rates of illness. Māori are 2.3 times more likely to experience and die from cardiovascular disease than non-Māori and Māori life expectancy is also significantly lower than the life expectancy for non-Māori.

Other minority groups in New Zealand also experience poorer health than the majority New Zealand European population. In particular, Pasifika still experience poorer health outcomes than the majority population. For example, Māori and Pacific communities have higher rates of diabetes. Māori and Pacific communities experience consistently higher infant mortality rates than the total New Zealand population, although this appears to be decreasing.¹⁷ Moreover, the obesity rates are greater for Māori and Pasifika.

Māori health

The New Zealand government has taken some important strides to address Māori health disparity. *He Korowai Oranga*: Māori Health Strategy sets the direction for Māori health development in the health and disability sector. The vision of *He Korowai Oranga* is the achievement of *whānau ora* (healthy families), and recognizes the desire of Māori to have control over their future, and to seek their own solutions and to manage their own services.

The New Zealand government has developed targeted action plans that set objectives for Māori health. *Whakatātaka* – the Māori Health Action Plan – was implemented in 2002, and was built upon by the second Māori Health Action Plan, *Whakatātaka Tuarua* 2006–2011.

As part of *Whakatātaka Tuarua*, the Ministry of Health has identified the following areas for priority: building quality data and monitoring Māori health; developing *whānau-ora*-based models; ensuring Māori participation; and improving primary health care.

Under the 2000 New Zealand Public Health and Disability Act, health services require community participation and have been decentralized. The Act created 21 district health boards (DHBs), which provide services that meet local needs. This system is important for Māori health as every board is legally required to have at least 2 Māori members out of its 11, and Māori membership of the board must also be proportional to the number of Māori in the district's resident population. Moreover, DHBs must include Māori health and *whānau ora* as priority criteria in resource allocation and disincentives decisions, and should set funding targets for investment in Māori health and disability, and report on targets for their regions to increase funding for Māori initiatives. However, in the 2012 assessment the auditor general found that DHBs have not always performed adequately and noted a lack of monitoring and reporting.¹⁸

Another important initiative for Māori health is the fact that each DHB must develop a Māori Health Plan (MHP), which aims to improve Māori health and reduce the disparities between Māori and non-Māori. As key planning and monitoring documents, the MHPs provide a summary of a DHB's Māori population and their health needs. The plan then documents and details the interventions and actions the DHB plans to undertake to address health issues in order to achieve indicator targets set nationally, regionally and at district level.

The New Zealand Ministry of Health has also been working together with Māori traditional healing practitioners. *Rongoā Māori*, the traditional healing, is formulated in a Māori cultural context; it encompasses the understanding of events leading to ill health and its impacts are addressed through a range of culturally bounded responses. These responses include *rakau rongoā* (native fauna herbal preparations), *mirimiri* (massage) and *karakia*

(prayer). In December 2011, a new national *Rongoā* governance body – *Te Kāhui Rongoā* Trust – was established to protect, nurture and promote *Rongoā Māori*, and aimed to become fully operational by June 2012.

Although it is too early to measure the success of the initiative, it remains significant, in particular in light of old repressive laws which banned traditional Maori healers (*Tobunga*) and outlawed *Rongoā Māori*. Although the law was repealed in 1962, the new Trust is one of the first initiatives to formally promote *Rongoā Māori* on the national level.

Health of Asian New Zealanders

It appears that many Asian migrants who arrive in New Zealand are relatively healthy, however this has been attributed to the ‘healthy immigrant effect’, which requires most migrants to be in good health in order to be allowed to immigrate to a new host country. However, this positive effect on health is reported to gradually diminish with increased length of residency.

In particular, data has demonstrated low use of primary health care, emergency health care and cancer screening for Asian people in New Zealand, particularly for Chinese New Zealanders. For youth this is particularly worrying, and 15 per cent of young Chinese New Zealanders reported accessing no health services at all, which was over three times the rate reported by other New Zealanders.

Another key issue is cardiovascular disease and diabetes for South Asian people. Indian people show the highest rates of self-reported diabetes of any ethnic group in New Zealand and they also show high levels of cardiovascular disease, similar to Māori.

Some of these challenges appear to arise from underlying structural obstacles for Asian New Zealanders as a minority group: these include a lack of knowledge of the New Zealand health system, cultural beliefs and approaches to health care that differ from the New Zealand system, and linguistic barriers. Mental health also remains a challenging area because of the degree of stigma attached to such illness in many Asian cultures, resulting in potential treatment delay and possible worsening of prognosis. ■

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ICELAND

ATLANTIC
OCEAN

IRELAND

UNITED
KINGDOM

NORWAY

SWEDEN

FINLAND

ESTONIA

LATVIA

LITHUANIA

Kaliningrad
(Rus.)

BELARUS

POLAND

NETHERLANDS

GERMANY

BELGIUM

LUXEMBOURG

CZECH REP.

SLOVAKIA

AUSTRIA

FRANCE

SWITZERLAND

LIECH.

HUNGARY

MOLDOVA

SLOVENIA

CROATIA

ROMANIA

BOSNIA
AND HERZE
MONTENEGRO

SAN MARINO

ANDORRA

MONACO

PORTUGAL

SPAIN

Kosovo

BULGARIA

MACEDONIA

ITALY

ALBANIA

GREECE

TURKEY

CYPRUS

RUSSIA

GEORGIA

ARMENIA

AZERBAIJAN

AZER.

BLACK SEA

Europe

Katalin Halász

Access to health care and the full enjoyment of the highest attainable standard of health is seriously limited for many ethnic, religious and linguistic minorities and migrants in Europe. The demand for health care is growing rapidly, as a result of ageing populations and demographic changes, but the delivery of equal, accessible and high-quality health services at affordable cost remains a distant goal.

The European Convention on Human Rights (ECHR) and the European Social Charter (ESC) of the Council of Europe are the main regional human rights instruments in Europe relating to health and human rights. Relevant articles in the ECHR relate to the right to life (Article 2), the prohibition of torture and inhuman or degrading treatment (Article 3) and the right to private and family life (Article 8). Article 11 of the Charter provides for the removal as far as possible of causes of ill health and the prevention of diseases as well as measures to promote health. However, when it comes to effectively implementing these provisions there are many shortcomings. Implementation is overseen by a supervisory mechanism based on a system of collective complaints and national reports, although it should be noted that only 15 of the 43 ratifying states have accepted the collective complaints procedure.

In 2012 the Médecins du Monde (MdM) published a study on health care provision for vulnerable groups in countries of the European Union (EU). The report provides evidence of the impact of the financial crisis on health and health-related issues. As minorities are often economically and socially excluded, they have been hit first by the wave of unemployment, economic hardship and poverty. This, combined with government cuts in health care spending and increased user charges for services, means that vulnerable groups are now even less likely to receive the necessary health care, while the number of people facing precarious living conditions is increasing.

The MdM research was conducted in health centres and backed by patient interviews in 11 countries. It raises grave concerns regarding the lack of access to primary health care and antenatal care for Roma, migrants and other

vulnerable groups. MdM urges EU member states and institutions to ensure health coverage for the most vulnerable people and tackle discrimination and social exclusion that cause ill health. The MdM study draws attention to an increasingly large number of undocumented migrants and refugees left without medical attention, which they link to the experience of frequent police harassment combined with the fear of being reported to the authorities and subsequent deportation.

These findings are confirmed by the European Network Against Racism (ENAR). The organization has also pointed to the poor health outcomes for ethnic and religious minorities and migrants, and highlighted the particular vulnerability of elder minorities and migrants. The ENAR has called for targeted measures particularly for older minorities and migrants in the framework of the 2012 European Year of Active Ageing and Solidarity between Generations.

According to the ENAR, significantly lower health outcomes and greater prevalence of certain chronic conditions among minorities and migrants of all ages are explained by a number of factors: discrimination; prejudice by staff and patients; communication and language barriers and the lack of interpreting services; cultural and financial barriers; poor working and living conditions; lack of information on health care entitlements; as well as legal challenges in accessing health care.

Research by the Fundamental Rights Agency (FRA) of the EU on inequalities in access to health care confirmed that language is a key barrier, particularly for minority older persons and women, who interact less with mainstream society and are more likely to be engaged in housework and in the home. Particular health problems in older age, like dementia or stroke, also contribute to the loss of ability to communicate in the majority language, which in turn makes diagnosis and treatment extremely difficult. Lack of consideration among health professionals of diverse cultural practices also prevents some groups from accessing health services. Muslim women, for example, can feel uncomfortable with male medical staff or interpreters.

Most of the trends and issues with relevance to minority protection identified in 2012 remain largely similar to those reported in previous years. Following the economic crisis and reduced financial support for equality and diversity programmes, and for human rights and minority organizations, there is a clear risk that fewer anti-discrimination cases will be brought forward and that there may be less scrutiny of the implementation of legal provisions.

In most EU countries, the shift towards more restrictive migration policies continued, particularly on access to health care. In September 2012 Spain introduced reforms to limit access to health care for adult undocumented migrant workers. Amnesty International and other non-governmental organizations (NGOs) have accused the government of breaking international agreements by excluding a significant section of the population from public health care.

Health care systems across Europe are struggling to balance concerns over reducing health care expenditure with how to guarantee existing human rights standards. A 2011 FRA report on the right to health for undocumented migrants in 11 EU member states maintains that the exclusion of irregular migrants from health care has a potential detrimental effect on the whole community. The FRA points out that while all those residing in a country should have access to certain basic health care, for example in case of a pregnancy or a serious illness, it is often seriously limited for migrants in an irregular situation.

The treatment of asylum seekers and the poor conditions of immigration detention centres in many European countries continued to be a great concern in the reporting year. Children and unaccompanied minors are often held in detention, which has a serious negative impact on their health. The International Detention Coalition has launched a campaign asking governments to stop detaining children and their families. Seventy-five organizations are supporting the campaign, including the European Council on Refugees and Exiles (ECRE), Amnesty International and the Jesuit Refugee Service. Adult detainees suffer from poor conditions in detention centres as well.

The continued rise of far-right nationalist ideologies is a worrying trend. During his trial that took place between April and June 2012, Anders Behring Breivik, the Norwegian mass killer behind the 2011 attacks, said he would do the same thing again and pleaded guilty. He was sentenced to at least 21 years' imprisonment on 24 August 2012. Breivik, who is supported by a number of far-right British extremists, including members of the English Defence League and the National Front, accused his investigators of creating a racist plot against him in order to discredit his extreme anti-Muslim ideology.

In Poland, the anniversary of the country's independence on 11 November turned violent in Warsaw when the police clashed with 20,000 neo-Nazi nationalists in Warsaw. As MRG has previously reported, far-right support does not only play out on the streets but in recent years has gained a foothold in many European parliaments as well. Hungarian member of parliament Marton Gyongyosi, of the far-right party Jobbik, called for public authorities to draw up a list of Jews in government positions as they pose a 'national security risk'. The Jobbik party is the country's third most powerful party, and is known for its anti-Semitic and anti-Roma rhetoric. Gyongyosi's call was vehemently condemned, not just by anti-racist and human rights organizations but also by the Hungarian parliament and government.

In parallel, racially motivated violence committed both by extremist groups and other perpetrators is a worryingly persistent aspect of European minority life. Two reports issued in 2012 by the FRA confirm that hate crime is a reality. The EU Minorities and Discrimination Survey (EU-MIDIS) provides evidence of ethnic minorities' experience of crime, including vehicle theft, burglary, assault and serious harassment. The first EU-wide survey of ethnic minority and immigrant groups and their perceptions of racially or ethnically motivated crime showed that 24 per cent of the 23,500 respondents said they had been a victim of crime at least once in the previous 12 months. On average, 18 per cent of all Roma and 18 per cent of all sub-Saharan African respondents indicated that they had experienced at least one racially motivated crime in the last 12 months.

In its study on victims' rights, the FRA showed that victims of hate crimes experience symptoms of severe trauma, such as depression, suspicion of others, self-blame and a profound sense of isolation. The physical harm resulting from hate violence is often less significant than the intensity of fear and anxiety, and the sense of violation, vulnerability and humiliation. Understanding the impact of hate crimes on individual victims is therefore essential in the provision of health care services and mental support. The FRA strongly recommends better training for those who work with victims, such as police officers, public prosecutors and judges. In many cases, however, victims and witnesses are reluctant to report crimes to law enforcement agencies, the criminal justice system or even to NGOs and victim support groups. As a result, perpetrators are rarely brought to justice, and victims are not adequately cared for by health services.

Violence against women also often goes unreported, and undocumented female domestic workers are particularly vulnerable to violence. According to the European Women's Lobby these women are more likely to continue enduring violence because of discrimination by police officers and because of the fear of deportation. In many cases, when undocumented women do report violence or domestic violence, they are not provided with medical and psychological support, shelter or access to justice.

In January 2012, Rashida Manjoo, the UN Special Rapporteur on violence against women, visited anti-violence shelters and detention centres in Italy's major cities, as well as Roma and Sinti community camps. She urged the country to do more to protect women from violence and provide psychological and economic support to victims. In Italy, a fragmented legal framework, inadequate investigation and punishment of perpetrators, and poor support for women victims of violence contribute to invisibility of this issue and the silence surrounding it. Undocumented migrant women are particularly vulnerable.

In December, the EU received the 2012 Nobel Peace Prize for its 'contribution for over six decades to the advancement of peace and reconciliation, democracy and human rights in Europe'. Human rights organizations

Right: A couple living in a Roma camp in Italy.
Robin Hammond/Panos.

recognized the EU's contribution to peace in Europe over the past 55 years, but warned that the past achievements are under growing threat if the EU does not maintain the central importance of defending human rights within its borders. Grave concerns remain: widespread discrimination across Europe against people from ethnic, religious and gender minorities; the social and economic exclusion of Roma; the failure to uphold the rights of migrants and refugees; and the growing number of hate crimes across the continent. Many minorities experience discrimination on multiple grounds. Women belonging to minority groups can be discriminated against based on ethnic, religious, gender and sexuality grounds for example. The regional legal framework remains inadequate with regard to providing adequate protection against discrimination. The prompt adoption and implementation of the proposed EU Directive on implementing the principle of equal treatment between persons irrespective of religion or belief, disability, age or sexual orientation (also known as the 'Horizontal Equal Treatment Directive') would help with addressing this legal gap, but the debate on the proposal has not moved forward significantly over recent years.

Roma

Roma, Europe's largest minority group, continued to face widespread discrimination and grave human rights abuses, including violent assaults, during 2012. UNICEF estimates that almost 50 per cent of the Roma population in Europe are under 15 (out of an estimated 10–15 million Roma). Many Roma are reported to have a poorer health status and worse access to health services than majority populations in many European countries.

According to a 2011 Open Society Foundation (OSF) study, Roma are disproportionately unvaccinated, have poorer than average nutrition, experience higher rates of low birth weight, infant mortality and tuberculosis. Social and economic exclusion and discrimination, poor housing and lack of access to appropriate health care also contribute to poor health outcomes.



Furthermore, as the OSF review states, Roma often cannot access health care because they lack identity cards or other documents required for health insurance. Roma are also disproportionately represented among the poor across Europe and often cannot afford to pay for medicine or transport to health facilities for example.

Experience of discrimination in health care settings deters some Roma from seeking medical help. In fact, between 11 and 23 per cent of Roma responding to a 2009 FRA EU-MIDIS survey reported that they had experienced discrimination in health services by health care personnel in the year prior to the survey.

These findings are echoed in the 2012 Council of Europe review, 'The human rights of Roma and Travellers in Europe' that, among other issues, discusses the right to health. The Council of Europe draws attention to the link between poor housing and health status. Segments of the Roma community live in slum housing, in close proximity to garbage dumps, and have no access to quality water and sanitation.

During his 2011 mission to Hungary, the UN Special Rapporteur on contemporary forms of racism, racial discrimination, xenophobia and related intolerance, Githu Muigai, visited Roma families living in public social housing in the north-east. Although housing projects have been established in Hungary and 160 anti-segregation plans were set up as part of the Decade of Roma Inclusion Programme, the UN Special Rapporteur found communities living in substandard housing without basic services and infrastructure, including running water and electricity. He also noted that, despite health care reforms in 2006, which included the setting up of a supervisory authority to receive complaints and training for medical staff, Roma still face discrimination and have a lower life expectancy rate.

During the extraordinarily cold winter of 2012 the number of fatalities among Roma across Eastern Europe was devastating. The European Roma Rights Centre (ERRC) called on the governments of Albania and Lithuania to stop forced evictions during the harsh winter.

In Vilnius – at a time when temperatures had dropped to under minus 30 degrees in the municipality – the authorities gave written notice to four families with six children under 12, including a six-month-old baby, informing them of plans to demolish their houses. The ERRC urged the authorities to respect, protect and fulfil the right to adequate housing, to suspend the planned evictions, and to find sustainable housing solutions for all affected families.

The year 2012 saw a number of landmark rulings in the European Court of Human Rights. In May the Court ruled that evicting Roma from Batalova Vodenitsa, on the outskirts of Bulgaria's capital Sofia, would violate the right to private and family life. The Court ruled in favour of 23 Bulgarian nationals living in the settlement with about 250 other Roma. Following the ruling, Bulgarian authorities cannot proceed with the eviction without safeguards and special consideration for the vulnerable, such as the elderly and children.

The Court also ruled in cases of violence. In its judgment of 12 June the Court found that Slovakia had failed to carry out an effective investigation into a violent attack against 10 Roma individuals in the town of Ganovice-Filice (in the case of *Koky and others v. Slovakia*). The 10 applicants were awarded a total of €55,000 in damages. In October, a Bulgarian Roma woman, Yolanda Kirilova Yotova, who was gunned down and disabled outside her house by a youth, was awarded more than €15,000 by the Court. The Court also ruled against Hungary for violating Article 3 of the ECHR in a case of excessive police force against a Roma woman.

These rulings set timely precedents, as an alarming number of attacks against Roma continued across the region. According to the ERRC, in the first half of 2012 alone, at least 20 attacks were carried out in four Eastern European countries (Bulgaria, the Czech Republic, Hungary, Slovakia) leading to 10 deaths of Roma people.

Armenia

The absence of political representation for minority communities and civil society organizations is also a key concern in Armenia. The country's largest minority are the Yezidis,

Case study

Forced sterilization of Roma women

After decades of silence, Roma women who were forcibly sterilized by the state in Eastern Europe have won their cases in the European Court.

Forced sterilization of Roma women remained unacknowledged in Eastern Europe for a long time, until a number of court cases brought the proportions of this shocking practice to light. In the Czech Republic, the practice of sterilizing Roma women without their informed consent has continued, with cases as recently as 2009.

In the past two years, the European Court of Human Rights has ruled in favour of a number of Roma women who had been forcibly sterilized by a Slovak state hospital. The Court declared that the practice constituted a violation of their fundamental rights.

'I am pleased that the European Court confirmed [our claims] and admitted that they sterilized us without our consent,' said one of the women, identified as I.G. in the case in November 2012. 'In my name, and the name of other Roma women, I thank the European Court,' she added. In its third verdict against Slovakia, the Court ruled in favour of the two plaintiffs (a third applicant passed away in 2010) and granted compensation of €28,500 and €27,000 and reimbursement of their legal fees. The applicants were the first who were willing to bring cases against doctors in Slovakia and inspired other women to come forward and do the same.

The applicants had submitted a complaint to the Court in 2004, claiming that they had been forcibly sterilized after caesarean sections at the hospital in Krompachy between 1999 and 2002. Legally minors at the time, they were asked to sign a document that they thought was required for delivery by caesarean section. The doctors sterilized

them without the consent of their legal guardians as required by Slovak law. It was only during an investigation years later that it was revealed the documents were actually requests for sterilization.

The Court followed the reasoning from its two recent judgments in *V.C. v. Slovakia* (2011) and *N.B. v. Slovakia* (2012). Finding that the sterilizations were not life-saving medical interventions and that they were performed without the requisite informed consent, the Court held that this treatment violated the right to freedom from inhuman and degrading treatment and the right to private and family life. The Court also found that Slovakia had failed in its obligation to protect the reproductive health of Roma women, and that it did not conduct a prompt and reasonable investigation as required by Article 3 of the ECHR.

These three important judgments were followed by yet another case, in June 2012, in which the Court significantly raised the amount of compensation awarded to the applicant by a Slovakian court, arguing that the sterilization caused her psychological suffering and had seriously affected her position as a woman in the Roma community.

The practice of forced sterilization of Roma women in Czechoslovakia started in the 1970s

and officially ended after the collapse of the communist regime in 1990. Systematic forced sterilization was used to curb the supposedly 'high, unhealthy' fertility rate among Roma and the practice continued after the break-up of the country into Slovakia and Czech Republic in 1993.

According to estimates by the Czech ombudsman, as many as 90,000 women from the former Czechoslovakia became infertile as a consequence of such interventions. In some cases in Czechoslovakia some Roma women were threatened or offered incentives to undergo the operation. Similar cases, but far fewer, have been reported in Hungary.

For years women who had been forcibly sterilized stayed silent, and some were even ashamed to tell their own husbands.

In November 2009, the Czech government expressed regret for 'individual failures' in carrying out sterilizations, but many women are still waiting for adequate redress. In December 2012 the Czech government settled out of court with a woman of Roma origin after she filed a complaint with the European Court of Human Rights in Strasbourg. The agreement included compensation of 10,000 Euros and the concession that the government was at fault.

Meanwhile, in Slovakia, the liberal opposition Freedom and Solidarity party (Svoboda a Solidarita – SaS) proposed in August 2012 that the state should introduce a subsidy for voluntary sterilizations for women over 35 who have more than three children. According to the authors of the draft law, the measures are a form of social benefit as the state would take over the costs of the operation, which could contribute toward reducing the 'extremely high birth rates in [Roma] settlements'. While the proposal was based on voluntary participation, it underscored the fact that sterilization as a form of social control is not a thing of the past. It remains an ongoing and inherently stigmatizing issue for Roma women. ■

Left: A woman stands in a Roma settlement, Slovakia. Bjoern Steinz/Panos.



with a population of about 40,000. Although the Armenian Ombudsman stated in a 2011 report that national minorities have favourable conditions for preserving their national identity, the chair of the Yezidi National Union voiced his concerns about the lack of minority language and cultural education of Yezidi children living in the capital. The chair of the World Union of Yezidis raised similar concerns, pointing at the lack of representation of the minority community in the National Assembly of Armenia. During an interview in March, the head of the Department for Ethnic Minorities and Religious Affairs insisted that the government had increased its financial support for Yezidis and Armenia's other minorities, in particular in the area of education.

In a recent move the government raised the legal age of marriage of women from 17 years old to 18 years old, the same as for men. This may lead to conflict with the Yezidi community, where girls get married as early as 13 or 14. The community insists that the change is 'inhuman' and will ruin their families. The government argues that the new minimum age will help eliminate gender inequality and bring the country into compliance with the 1979 UN Convention on the Elimination of All Forms of Discrimination against Women.

Azerbaijan

Minority groups in Azerbaijan face long-standing discrimination and harassment and lack of consultation within decision-making processes. The country's main minority groups include Lezgins (2.2 per cent), Russians (1.8 per cent), Armenians (1.5 per cent although this figure is contested) and Talysh (1.0 per cent).

The Farsi-speaking Talysh community in Azerbaijan has come under scrutiny from the government as it has cracked down on civil society in the aftermath of the Eurovision Song Contest that the country hosted in 2012. Most of the Talysh live in southern Azerbaijan, mainly in rural areas near Iran. Four Azerbaijani human rights organizations, the Human Rights Club, the Institute for Reporters' Freedom and Safety, the Institute for Peace and Democracy and the Alliance for Defense of Political Freedoms, used the occasion of the song contest to raise awareness about forced evictions and arrests and

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Case study by Jack Denith
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Bulgaria: community monitoring improves access to health services for Roma

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A campaign run by Roma NGO Amalipe has improved awareness of health issues and rights, and access to health services.

Roma in Bulgaria live, on average, 10 years less than ethnic Bulgarians. High rates of poverty among Roma communities combine with other socio-economic factors to adversely affect their health and their ability to access adequate health care. For example, a 2011 survey carried out by the United Nations Development Programme, the World Bank and the European Commission found that 48 per cent of Bulgarian Roma had medical insurance, compared to 85 per cent for non-Roma living in the same area.

National legislation has been drawn up to address these inequalities, but implementation of these policies has been 'close to zero' say Lyubomir Lazarov and Deyan Kolev of the Amalipe Center for Interethnic Dialogue and Tolerance, a Roma NGO. Although the legislation sounded good on paper, there was a lack of financial and administrative support for the proposals, and no mechanisms to allow participation by Roma communities.

In 2011, Amalipe decided to put Roma at the heart of assessing and monitoring health services in Bulgaria. Following a model first proposed by Abhijit Das of the Public Health Institute in India, Amalipe developed a system to enable communities to monitor

health care services themselves, and carry out their own research into their own health needs and how local services met (or failed to meet) them.

Amalipe established local volunteer clubs that brought young people, women and informal leaders together with trained moderators (also from the community) to discuss health issues. Together with the Amalipe project team, these community organizations conducted surveys of the health of Roma women and their use and knowledge of health care services. They also developed a health information campaign using community theatre.

The challenges were substantial: not only in terms of Roma health, but also in terms of the barriers to improving access – from poor diet and an inability to afford medication, to facing discrimination from medical staff. High rates of poverty make health insurance a rare luxury for the majority of Roma, while the rural areas where many Roma live have only a few general medical practitioners working insufficient hours to cover the population.

The surveys found that these factors were compounded by a lack of awareness of health issues, such as what rights to health people have, or what services are available (half of the women surveyed by the communities did not have information on when doctors visited their village). These issues were influenced in turn by Bulgarian and Roma scepticism about the ability or willingness of civil institutions to create positive change.

Through the information campaign, advocacy activities of the project team and free gynaecological checks organized within the project, the Roma communities improved access to a number of health services, from primary health facilities to emergency and hospital care. From simple measures such as raising awareness about what services are available to communities and what they are entitled to receive, substantial improvements were made by the communities themselves. ■

police brutality against journalists in the country. The awareness campaign, known as ‘Sing for Democracy’, was joined by 30 local NGOs and 15 international human rights watchdogs. President Ilham Aliyev accused civil society leaders, human rights activists and journalists of trying to ruin the country’s reputation.

The arrest of a prominent Talysh advocate on separatism charges was condemned by human rights defenders as politically motivated. Hilal Mammadov, a mathematician and newspaper editor, was arrested on charges of treason and espionage for Iran in June. His predecessor on the Talysh-language *Tolyshi sado* paper, Novruzali Mammadov, was arrested in 2007 after he published an article on the history of the Talysh; he died in prison in 2009, while serving his 15-year sentence. In July human rights activists and Talysh representatives organized a press conference in Moscow in order to demand the release of Hilal Mamedov, who was arrested in June on bogus drug possession charges. Pre-trial hearings commenced in January 2013, and the trial continued in March and April 2013. Mammadov’s request that the trial be public was rejected by the judge.

Germany

Germany’s minorities face difficulties accessing health care. Turks in the country tend to visit hospitals because of their mistrust of general practitioners (GPs), according to the German newspaper *Die Welt*. A 2012 analysis by the MdM showed that 68 per cent of the patients visiting their centre in Munich only had access to emergency care in hospitals, and only 8 per cent were covered by health insurance or by the health insurance system of their country of origin. Greater use of hospital for treatment by minorities is not only more expensive, it also often means a delay in treatment and increases the likelihood of surgery being needed.

Language barriers are one of the main issues when trying to obtain health care for minority groups. Even those whose command of German is excellent tend to be less informed during hospital visits than the majority population. Translators are not only relevant for minority members who do not speak sufficient German or who require psychotherapy, they are also needed

for an ageing population in which minority members whose first language was not German may lose their language skills due to dementia or Alzheimer's disease. Access to primary care and preventative medicine is also problematic. Although Germany has a culture of regular health check-ups and health monitoring, minorities often only see doctors when they are already sick or feel at risk of illness, which means they often miss out on preventative medicine and health check-ups for children. The MDM study noted that, whereas in other European cities, lack of knowledge about patients' rights was the key barrier to accessing health care, this was hardly an issue at their treatment centre in Munich since the vast majority of visitors, lacking permanent residency, hardly had any rights at all.

Minority children whose parents both come from a migrant background are also more likely to be overweight and have bad teeth than majority children, which is partly due to lack of preventative medicine and dental hygiene. Integration and social status play a role as well: the more well-integrated (assessed on the basis of language proficiency and resulting improved social status and employment situation) and more wealthy minority families are, the less likely they are to suffer from hepatitis, tuberculosis and other poverty-related illnesses, and the more likely they are to report allergies.

Inclusion and full participation in Germany's social and economic life is a constant and unresolved issue for minority groups. Under-representation of minorities in the public sector is a fact, which Chancellor Angela Merkel has said she wants to change, after leading a national integration summit in Berlin in January. The German government confirmed that it wanted to visibly increase the number of immigrants working in the public sector, which, according to national integration commissioner Maria Böhmer, served as a model for the rest of the labour market. Whether the government does a better job of ensuring the public sector reflects the demographics of the country remains to be seen. According to a study by the Organisation for Economic Co-operation and Development (OECD), Germany takes a 'sad last place' compared to the 34 other member states of the OECD when it comes to the number of

Right: Doctors examine a man of African origin at a medical centre in Greece.

REUTERS/John Kolesidid.

descendants of migrants working in the public sector.

A ruling on circumcision that was handed down by a court in Cologne in June sparked an outcry among Muslim and Jewish communities and led to joint protests in the country. The judge ruled that the circumcision of a young boy on religious grounds amounted to grievous bodily harm and contravene the right to choose religion freely in later life, and was therefore illegal. The case arose when the circumcision of a Muslim boy had gone wrong and the boy was admitted to hospital. 'We consider this to be an affront [to] our basic religious and human rights,' stated the unusual joint statement, signed by leaders of the Rabbinical Centre of Europe, the European Jewish Parliament, the European Jewish Association, Germany's Turkish-Islamic Union for Religious Affairs and the Islamic Centre Brussels.

In September the state government in Berlin announced that circumcision was legal there, as long as it was properly carried out. The federal government also responded by stating that it wants to legalize the procedure explicitly and proposed a new law. According to the draft law, circumcision is legal in Germany. In the first six months of a boy's life, it can be performed by a member of the boy's religion who has received the necessary training or a doctor. After that age, it can only be performed by a doctor. The German parliament approved the bill in December.

Greece

Violent attacks and racist and xenophobic political activities intensified in the country after the neo-Nazi extremist party Golden Dawn won 6.9 per cent of the votes for the Hellenic Parliament in June. In December the European Commission against Racism and Intolerance (ECRI) of the Council of Europe urged the Greek authorities to take firm and effective action to ensure that the activities of Golden Dawn do not violate the free and democratic political order or the rights of any individuals.



At the same time, illegal immigration remained a real political issue for the country, which is already struggling with the impact of the eurozone crisis. According to the European Commission, 40 per cent of the Middle East and South Asia migrants who entered the EU without the required documents in 2012 came through Greece. The country, which is due to complete a 12.5 km long anti-migrant wall along its Turkish border, deployed 1,881 additional guards on its border to prevent a surge of Syrian refugees from Turkey.

The poor treatment of refugees and asylum seekers is an ongoing concern. The UN Special Rapporteur on the human rights of migrants, François Crépeau, urged the country to protect migrants but at the same time underlined the responsibility of the EU to fund and support measures to establish a civilian asylum and first reception centre that would effectively screen migrants with vulnerabilities. He had himself

witnessed many unaccompanied minors without documentation living under highway underpasses and without any government support.

Meanwhile, in August, authorities carried out one of the country's biggest crackdowns on suspected undocumented migrants in Athens, deploying 4,500 police officers in the capital and detaining more than 7,000 migrants in less than 72 hours. Most were released, but about 2,000, mostly from Africa and Asia, were arrested and sent to holding centres pending deportation. The first detention centre for undocumented migrants opened in April. The centre, north-west of Athens, which is composed of box homes and is surrounded by high wire fences, is meant to house some 1,200 people. A further 50 centres are planned to be built by mid-2013. Previously, plans were announced by the government to hold illegal immigrants in detention for compulsory health checks and treatment for HIV/AIDS and other contagious ailments, and hold them

indefinitely if they are considered a risk to public health. In its 2012 overview of the conditions of persons excluded from health care systems in the EU, MdM stated that over 70 per cent of the violence suffered by migrant patients occurred after their arrival in the country.

Throughout 2012 brutal assaults against migrants by people affiliated to Golden Dawn and by other perpetrators were steadily increasing. In Crete, a 25-year-old homeless Egyptian man was beaten with metal bars. He had to have life-saving surgery, which ended with the removal of a kidney. Just a day before, a group of four men attacked two Algerian migrants with iron and wooden bars and knives. The two men in their mid-20s were treated for extensive head injuries and stab wounds. Police arrested 25 men in connection with an attack on a Pakistani man at the Attiki metro station and confirmed that many were members of the Golden Dawn party. The party has several initiatives related to health (such as blood supplies) that are open for Greek citizens only if they can prove they have a Greek father and show a Greek identity card. Civil society and private initiatives, however, have launched programmes that help all people, including minorities. The Boroume non-profit organization for example organizes the distribution of surplus food for charity throughout the country.

Russia

In 2011 the Advisory Committee on the Council of Europe's Framework Convention on National Minorities sharply criticized Russia on the lack of participation of persons belonging to national minorities in public life, which is limited to the organization of cultural events. According to the Advisory Committee, there are no effective consultation mechanisms in place to ensure that minorities have an opportunity to influence effectively decisions on issues concerning them.

In July 2012, the UN High Commissioner for Human Rights Navi Pillay also expressed concerns that a series of legislative amendments in the Russian Federation would seriously restrict human rights in the country. 'In just two months, we have seen a worrying shift in the legislative environment governing the enjoyment of the freedoms of assembly, association, speech

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Case study by Rita Bence
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Hungary: Roma children arbitrarily separated from families

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The case of a Roma woman whose children were taken away because of alleged 'mental disabilities' shows how social services are failing vulnerable families in Hungary.

The Hungarian Civil Liberties Union has been representing a case that shows eloquently how the most vulnerable people can be abused and how authorities treat them arbitrarily, affecting the most important aspects of their lives.

A 20-year-old woman called LV was placed under guardianship because of alleged 'learning disabilities'. She has two children, both of whom were taken away from her by the authorities who said that she is not able to take care of them. She has a partner, a 40-year-old man, who is her guardian and lives together with her in quite poor circumstances but they can make ends meet. This man is the father of the two children though he is not registered as such officially.

LV maintains the household and takes care of two of her sister-in-law's children. According to a medical examination she

and information in the Russian Federation,' she said. 'At least four new legal provisions have been made that will have a detrimental effect on human rights in the country.'

Of concern are the restrictive amendments to the law on public rallies, a bill limiting freedom of information on the internet, the restoration of defamation provisions into the Criminal Code, and a restrictive new law on non-commercial organizations, which would effectively require all

has been diagnosed with a minor learning disability. Although we are not physicians, it seems obvious that she is a loveable and responsible woman who is able to take responsibility for her deeds and looks after children every day. Despite all these facts, both of her children were taken away by the child protection authority. They justified this decision stating that 'she is disabled' and her partner, who is also her guardian, has three other sons, so they are too poor to provide for the children.

She was given no information about where the first child went; she cannot even contact her and is not allowed to visit her. The second child was taken away soon after she arrived home from the hospital after giving birth. She could visit her little son only once a week. At first the boy was placed in an institute; later he was placed with foster parents. LV usually travelled many kilometres alone by bus to see her son; she knows the timetable and the fares of the line, which is more evidence that she is well-oriented.

The most troubling aspect is that it is everyday practice to take children away from their parents in the area where this couple lives. The authority did the same thing in the case of LV's mother and sister-in-law. This happened against the explicit request of the affected families.

The Hungarian Civil Liberties Union appealed in the child custody case, and sued the authority to end its guardianship of LV.

Due to the appeal the authority was obliged to repeat its procedure because of

several substantive and procedural mistakes. Fortunately, the child protection authority decided to give back the little son to his mother.

The lawsuit referring to guardianship is still in progress. The approach of the judge clearly shows strong discrimination. At the first trial she spoke to LV and her family rather arrogantly; she asked irrelevant questions and tried to confuse them.

According to Hungarian law, people under guardianship can be deprived of the right to vote. This happened to LV too, and we want to help her to retrieve it. In this regard the judge asked extremely difficult questions, such as: 'What is your opinion about the Fourth Amendment of the Fundamental Law?' This question cannot be a measurement of the voting capacity, because plenty of average people cannot answer this.

We are hoping for the best outcome of the lawsuit. We are planning to appeal if necessary, as we want to hinder such discriminative and arbitrary procedures.

The fact that Roma people generally live in extreme poverty makes them more vulnerable, and they often do not know how to go about defending their rights. Authorities mostly abuse these situations through obscure administrative procedures that impair the innate human rights of Roma. The situation is very difficult for LV. She knows that the health and development of her children may be at risk if they are forced to grow up in care. ■

NGOs that receive foreign funding to register as 'foreign agents'. Under the provisions, NGOs involved in politics and receiving foreign funds will have to issue twice-yearly reports on their activities and financial audits. Because of limited state support, many NGOs need to seek foreign funds. Failure to comply will be punishable by heavy fines or even a two-year prison sentence. Journalists and human rights activists see the bill as an attempt to crush dissent and restrict

freedom of expression.

Another move of the government on civil society that sparked international opposition in 2012 was the closure of Russian's indigenous peoples' umbrella organization RAIPON, because of an 'alleged lack of correspondence between the association's statutes and federal law'. According to Russia's Ministry of Justice, which ordered the closure in November, the indigenous peoples' association will be closed for



Above: An indigenous reindeer herder sits on his snowmobile, Russia. *Justin Jin/Panos.*

six months until the statutes have been adjusted. For over 20 years RAIPON has represented more than 250,000 indigenous people from 40 groups inhabiting huge Arctic territories of the Russian Federation from Murmansk to Kamchatka. Its first vice-president, Pavel Sulyandziga, a Russian indigenous rights activist of Udege nationality, said that the decision was illegal and he is determined to fight it.

This will be not an easy task given the strong stance of President Vladimir Putin, who in January warned that ethnic tensions could tear Russia apart. He stated that he would toughen migration rules and keep a tight rein on Russia's regions to prevent it following the Soviet Union

into oblivion, and that minorities in what he called a multi-ethnic society must live under the umbrella of Russian culture.

Among the most vulnerable groups in Russia are the country's indigenous peoples. Although there is no unified system of health monitoring of indigenous peoples, some general trends show significantly lower average health outcomes compared to majority populations. According to the 2002 Census the average life expectancy of Russian indigenous peoples was 15 years below the Russian average. Equally, for these groups, the disease-propensity is 1.5 times higher than for central Russian peoples. This includes a significant increase in diseases such as tuberculosis, hepatitis and illnesses spread through parasites (see case study).

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Case study by *Irina L. Stoyanova*
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Indigenous health care system in the remote areas of the Russian north

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High prevalence of tuberculosis and other infectious diseases, particular problems with alcohol and mental health, and difficulties accessing health care are among the most pressing health problems facing indigenous peoples in Russia's far north.

There are few studies and little data on the health of indigenous peoples in the Russian Arctic, because these groups live in remote areas with few medical services. Considerable variation exists across the different regions of the Russian north, influenced by local geographic, ethnic, administrative and political factors. Nevertheless, the following general observations about Russian indigenous peoples' health can be made.

As of 2004, the average life expectancy of Russian indigenous peoples was 15 years shorter than the Russian average. Mortality rates are significantly above the national average; infant mortality rates are estimated to be twice as high as the national average. Poor health and other factors have led to drastic declines in the indigenous population and some small indigenous groups have reached the brink of extinction.

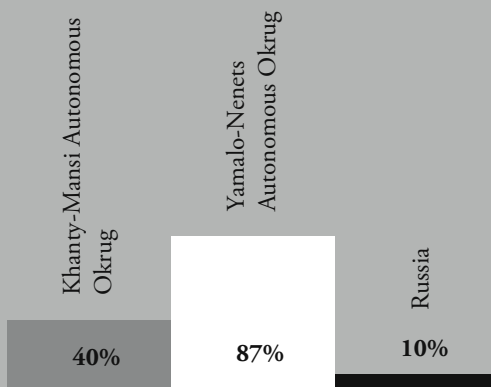
Changes in traditional diets, together with a general decrease in physical activity, have significantly impacted the health of the indigenous population. A contributing factor for the increase in diabetes, obesity

and anaemia is the increasing use of imported store-bought, 'ready-made' foods and decreasing consumption of traditional foods such as meat and local plants.

Infectious diseases, particularly tuberculosis, and sexually transmitted infections are a growing problem. The prevalence of tuberculosis among indigenous peoples of the Russian north is almost five times higher than among non-indigenous people, and the death rate is almost nine times higher than among the non-indigenous population. Rates of active tuberculosis for Siberian Inuit, for instance, are alarmingly high. The mortality due to this disease is as high as 40 cases per 100 persons in the Khanty-Mansi Autonomous Okrug and in the Yamalo-Nenets Autonomous Okrug this index is 87, whereas in Russia this average index is 10.

Tuberculosis is a particular problem for indigenous peoples because of the effect of low temperatures, reduced immunity and poor living conditions. In Krasnoyarsk Krai, for example, the spread of tuberculosis in the last three years is particularly exacerbated due to lack of clean drinking water and adequate sewerage systems. Poor sanitation and hygiene conditions of the population in northern settlements greatly contribute to the spread of not only tuberculosis but also other infections, such as dysentery, hepatitis and parasitic worm infestations.

Access to healthcare and medicine



Tuberculosis mortality rates

Case study continued

The remoteness and small size of indigenous settlements affects access to and the expense of medical care. All indigenous peoples of Russia are entitled to free medical care system coverage, which includes a compulsory annual check-up at state and municipal health care facilities. Yet federal and regional health care programmes do not always provide medical brigades to visit remote areas. For example, the village of Pareni in Kamchatka has reportedly had no access to medical care for two years. In Chukotka, it takes up to 28 hours for medical attention to be received. In remote villages the only way to receive medical help is via a scheduled flight or air ambulance service.

Medical personnel often lack modern, mobile equipment that allows them to go out and examine the population in remote settlements, such as reindeer herding camps. Nomadic reindeer herding is the traditional livelihood of many indigenous peoples of the Russian north. Working with indigenous peoples out in the tundra is complicated due to the practical difficulties of carrying out examinations in the constantly moving reindeer herding camps, as well as difficulties with controlling the prescribed treatment.

Poorly equipped health care facilities and lack of investment mean that it is extremely difficult to retain medical staff and attract specialists to come and work in rural hospitals. According to Dr Victor Mizernyuk, the Head Physician at the Lovozero Central Municipal Hospital: *'To rely on the indigenous population and give them*

medical education doesn't seem to be an option, since the young physicians after graduation from medical school, won't go back home, no matter how you try to entice them. The situation is extremely difficult – our own people don't come back, and outsiders don't come to the countryside.'

Alcohol dependency and mental health

Another serious problem facing Russian indigenous populations is alcohol dependency. The Committee on Northern Affairs and National Minorities states in its materials that over the past 10 years there has been an almost twenty-fold increase in alcohol abuse among indigenous peoples, particularly among women and adolescents. In the Yamal region, for instance, there is a serious concern about girls smoking and becoming addicted to alcohol as they mature and become mothers in the future. A growing proportion of indigenous households' income goes on purchasing alcohol.

Studies demonstrate that alcohol abuse in the Russian north is linked with a range of social and economic factors. Problems arise when reindeer herders move to permanent settlements. The ever-growing availability of liquor and advertisements for beer and alcohol beverages, the isolation of the parents from their children, who are away at boarding schools, and the stressful effects of 'modernization' are among the factors that often lead to alcohol dependency. This is why awareness of the particular psychological issues facing indigenous peoples is important if effective psychotherapeutic help is to be offered.

The steady growth of suicides and violent behaviour among the indigenous populations in

Turkey

While the Turkish government's approach to minorities in 2012 'remained restrictive', in the words of the European Commission's assessment of Turkey's progress towards EU membership, there were signs of increasing respect and interest in protection for minority rights.

The Constitution Conciliation Commission (CCC), composed of members from the four parties represented in parliament and formed to oversee changes to Turkey's Constitution, failed to reach consensus on key issues affecting

marginalized peoples in 2012, although it maintained promising dialogue with group representatives. For the first time, minorities other than those officially recognized by Turkey were invited to parliament, to express their views on a new Constitution. Currently only Armenians, Greeks and Jews are officially recognized as minority groups.

In February parliament heard a submission calling for legislation against hate crimes from a platform of 60 groups representing a wide range of minorities, including Alevi, Christian, Roma,

the Russian north is another alarming trend. Suicide rates are up to four times the Russian average. The Yamalo-Nenets Autonomous Okrug and Koryak Okrug have some of the highest rates in the world: 133.6 cases per 100,000 people. In comparison, the national suicide rate average is approximately 38 cases per 100,000. Homicide rates are correspondingly 70 per 100,000 among indigenous peoples, and 27 per 100,000 for the national average.

Also reported among indigenous peoples of the Russian north are mental disorders and poisoning by drugs and toxic substances. A large number of mental disorders – significant delays in development, signs of emotional distress and psychological tension – are found in indigenous children and the prevalence of these conditions is increasing with each year.

Urgent areas of action

It is important to:

- Collect reliable data on the health and living conditions of indigenous groups in Russia. The federal and local authorities need to enact legislation for the introduction of mandatory unified statistical health reports and annual monitoring of the health of indigenous peoples.
- Train medical personnel to consider the conditions in the north and the specific psychological challenges facing the indigenous peoples, and provide better training for doctors and nurses from among the residents of remote areas. ■

LGBT and disability rights groups. Similarly, Turkey's foreign minister Ahmet Davutoğlu held an unprecedented meeting with Greek Orthodox Patriarch Bartholomew at the patriarchate in Istanbul. The Patriarch also proposed new constitutional protections for religious minorities and religious freedom to the CCC. In May a proposal from the Republican People's Party and the Peace and Democracy Party, which would make the state responsible for eliminating discrimination against women, was rejected by the other two parties. Prime Minister Recep

Tayyip Erdoğan has suggested that a referendum will be needed in the second half of 2013 even if all parties reach a consensus on a new Constitution.

Nevertheless, prevailing attitudes in government and the media towards minority groups remained a cause for concern in 2012. The European Commission noted that there had been no progress in introducing legislation against hate speech and hate crimes, as recommended by the Council of Europe. Studies of news reports in 2012 by the Hrant Dink Foundation found that the prevalence of direct and explicit hate speech in opinion columns and news articles was double that of 2011. The Hrant Dink Foundation was set up after the assassination of Turkish-Armenian editor Hrant Dink in 2007. In January 2012, more than 20,000 people marched to mark the five years since his murder, and to protest a court ruling that there had been no state complicity in the assassination; the court's decision was later reviewed by the Supreme Court. In May 2013, the Supreme Court acknowledged that there had been a criminal conspiracy; the new decision paved the way for a retrial.

The situation for Roma in Turkey remained difficult, characterized by discrimination, prejudice and restricted socio-economic opportunities. In June, an administrative court cancelled a redevelopment project in the predominantly Kurdish and Roma Balat neighbourhood in Istanbul after five years of wrangling, and the controversial Sulukule project in Istanbul's Fatih municipality (which had resulted in the eviction of thousands of Roma in 2008) was also cancelled. However, the mayor of the municipality was confident that the state court would overturn the Sulukule ruling.

There was an increase in the number of Turkish applications to the European Court of Human Rights for the sixth year in a row, with most cases concerning the right to a fair trial and protection of property rights.

In August, a number of minority foundations reported that the process for returning property held by the government was dogged by bureaucratic problems and a timeframe that was too short to allow the foundations to make their claims. Between August 2011 and January



31, 2013, approximately 300 properties were returned to minority foundations (which often comprise religious communities).

Although the conflict between government forces and the Kurdistan Workers' Party (PKK) continued in 2012 with bombings and counter-insurgency operations causing deaths

and displacement on both sides, talks began in October to negotiate a ceasefire. In early 2013, the implementation of a ceasefire between the government and the Kurdistan Workers' Party (PKK) held the promise of bringing an end to decades of violent conflict.

While the government promised to recognize



Left: Kurdish girls in Turkey take a break from their jobs in a textile workshop.

Carolyn Drake/Panos.

International that the 20-year limit on judicial settlement is imminent for many cases, and they face being ‘timed out’ of receiving compensation through the courts. Ensuring that cases are settled and judgments enforced represents an important step towards ensuring sustainable peace in Turkey.

In November, Amnesty International reported that prison doctors routinely refuse to conduct medical examinations of Kurdish prisoners on hunger strike. Kurds in Turkey suffer from discrimination in accessing health care; for example, Kurds may be unable to access medical services in their own language. Although there are concerns about the effects of the privatization of Turkey’s health care system on the poorest citizens, south-east Turkey’s reputation for treatment in hospitals staffed by Kurdish speakers has attracted Iraqi Kurds to cross the border for medical services. Although provision of services in Kurdish is still far from comprehensive, the Turkish health system still offers better services for Kurds than neighbouring Iraq.

The conflict in Syria had an increasing impact on Turkey during 2012, as the numbers of registered refugees rose from 9,500 in January to 144,755 by the year’s end, in spite of restrictions put in place in August. ■

Kurdish ethnicity through constitutional reform, there remain political obstacles to achieving this and ensuring the stability of the peace agreement. While some cases of financial and legal settlement for crimes committed by the state against Kurds in the 1990s were settled in 2012, it was noted by Human Rights Watch and Amnesty



LIBYA

LEBANON

SYRIA

ISRAEL/OT/
Palestinian Authority

JORDAN

EGYPT

IRAQ

KUWAIT

IRAN

SAUDI ARABIA

BAHRAIN

QATAR

U.A.E.

YEMEN

OMAN

ARABIAN
SEA

Middle East and North Africa

Said Shehata

In 2012, the Middle East and North Africa witnessed several dramatic changes that affected ethnic and religious minorities in different countries. Egypt elected its first Muslim Brotherhood president, Mohamed Morsi, and the country experienced waves of violence and instability after he came into office.¹ Morsi was a polarizing figure and steps taken by his government caused concern among minority communities. While the number of fatalities and injuries from sectarian violence decreased in 2012 compared to 2011, Coptic Christians continued to experience attacks on churches and properties throughout the year, and some were imprisoned. The violence reached its peak a few months after year's end with an attack on the Coptic Orthodox Cathedral, seat of the community's Pope, in April 2013.

During 2012 the 'Arab Spring' turned into an 'Arab Autumn' in Egypt and other countries, such as Libya, Tunisia and Yemen. A 2012 Pew Center study found that the Middle East and North Africa region ranked the worst with regard to government restrictions on freedom of religion and religious sectarian violence; according to the Pew Center, governments in the region are more restrictive than anywhere else.

In Libya, there were elections for the General National Congress in July, but there were disputes about representation of some areas, such as Jebel Nafusa. At the same time there were several incidents of violence, since the government was unable to control the militias. The American ambassador to Libya was killed in Benghazi in September. Prime Minister Ali Zidan formed a new government, which was approved by the General National Congress in October. Zidan attempted to forge a broad coalition by including liberals and Islamists in his cabinet. Meanwhile, the situation for minorities remained serious, with non-Arabs and Christians being targeted by militant groups. Black Libyans, including persons of sub-Saharan origin, were particularly vulnerable. The population of Tawergha remained displaced, after having been forced out of the city in August 2011 by armed groups from Misrata.

In Iraq, there were hundreds of incidents of violence and in one day more than 100 people were killed. The number of civilian casualties increased. The political scene continued to

be characterized by deep divisions. Tariq al-Hashimi, the Sunni vice-president, was sentenced to death *in absentia* on terrorism charges, but he insisted that the charges and sentence were politically motivated. Tensions in the government reflected the fraught relations between the Sunni and Shi'a Muslim communities. Christians, Turkmen, Yezidis and other minorities in Iraq continued to be targeted, and large numbers remained displaced. For smaller minorities, such as the Sabean Mandaean, their continuing existence as a community is in doubt.

In Syria, the violence increased for the second year since the uprising in March 2011. According to the Office of the High Commissioner for Human Rights (OHCHR), nearly 93,000 people had been killed by spring 2013. By the end of 2012, 750,000 had left the country, and well over 2 million people had been displaced inside Syria. Minorities, such as Christians and Alawites, fear being targeted if the Bashar al-Assad regime collapses. There were cases of Christians being forced to leave their houses and flee for their lives by both government and anti-government forces.

In Saudi Arabia, Shi'a Muslims continued to face arrest and detention. In Iran, the regime continued to discriminate against minorities. There were executions and imprisonment of members of different ethnic and religious minorities in 2012, including Ahwazi Arabs.

Across the region then, the picture is gloomy. There is an urgent need throughout the Middle East and North Africa to ensure the protection of minorities, in accordance with UN instruments of human rights and minority rights. Secular authoritarian regimes, as in Syria, have sought to convince minorities that they are safer when their forces remain in control. However, in the long term, this strategy is fraught with danger for minorities, as they risk being targeted by opposition forces as having been too closely linked to such regimes. Clearly, true democracy remains a distant prospect for both minorities and majority groups.

Egypt

In June 2012 the country elected its first Islamist president, Mohamed Morsi of the Muslim Brotherhood's Freedom and Justice Party. This

marked a turning point for Egyptians generally and minorities in particular. There were hopes that Morsi could be a president 'for all Egyptians', as he said on several occasions, but Morsi excluded opponents from decision-making processes and appointed members of the Muslim Brotherhood to key positions in government.

Morsi faced repeated controversy in taking some decisions, such as setting the date of the House of Representatives elections for April 2013, despite widespread fears that the country was not yet prepared, and with regard to the reinstating of the People's Assembly (the lower house of parliament) in July, despite a ruling by the Supreme Constitutional Court that the electoral law was flawed. Morsi was also criticized for rushing the draft Constitution to referendum in December. Although nearly two-thirds of voters backed the new Constitution, it was widely criticized for ignoring women and not going far enough to protect minorities. For example, Article 43 affirmed freedom of religion but limited it to Islam, Christianity and Judaism – risking the further exclusion of Bahá'is. Several articles appeared to criminalize defamation of religion; similar clauses or legislation in other countries have led to the targeting of minorities.²

Religious minorities, including Copts, Shi'as and Bahá'is, continued to experience discrimination and their situation did not improve in 2012. There has been an increase in attacks on Christians and churches in Egypt since the fall of the former regime. The Egyptian government has failed or been slow to protect Copts, who comprise about 10 per cent of the population, and other religious minorities.

There were a number of incidents in which Copts and churches were targeted during the year. In January 2012, homes of Copts in Sharbat village, near Alexandria, were burned following rumours of an alleged relationship between a married Muslim woman and a Christian man. In February, eight Christian families were evicted from the village by police, and local religious and political figures, reportedly following a so-called 'reconciliation' session. The eviction was overturned two weeks later after media campaigns and a visit by some parliamentarians to the village; however no one was prosecuted. In August, in Dahshour, Giza governorate, about

100 families escaped after Christian homes and shops were set on fire.

While the number of fatalities and injuries from sectarian violence fell in 2012 compared with 2011, the situation remained very serious and escalated in early 2013 with the attack on the Coptic Orthodox St Mark's Cathedral, seat of the Coptic Pope Tawadros II, in April 2013. Two people were killed and over 80 were injured. Police fired tear gas into the compound and were accused of standing by as assailants attacked those inside. The congregation had gathered to mourn four Copts who had died the weekend before in religious violence in Khosous. A Muslim also died in that earlier incident.

During 2012 a number of Copts were imprisoned on blasphemy charges. In September Bishoy Kameel, a Copt from Sohag, was detained and then sentenced to six years in prison after posting cartoons on Facebook allegedly insulting to the Prophet Muhammad and President Morsi. Also in September, Alber Saber, an atheist from a Coptic family, was sentenced to three years' imprisonment on blasphemy charges with regard to both Islam and Christianity. He posted videos critical of religions. He was released in January 2013 and left the country. In contrast, Ahmed Mohammed Abdullah, known as Abu Islam, mocked Christianity on his TV show and tore the Bible in front of the American Embassy in Cairo. He was tried but released on bail.

In May, 12 Copts in Minya were sentenced to life in prison and eight Muslims were acquitted by an Emergency State Security Court in connection with clashes between Muslims and Christians in 2011. No Muslims were jailed on this occasion. The case went to retrial in January 2013.

The violence and lack of accountability gave rise to a growing climate of impunity. Moreover, legislation remained in place requiring official permission that made it difficult for Coptic communities to construct churches; no new churches were built during 2012. A rising number of Copts were leaving the country by the end of 2012, according to community leaders.

Shi'a Muslims, Bahá'is and other religious minorities also face discrimination. Analysts fear that Egypt is becoming increasingly divided along religious and political lines. The lack of

official recognition of Shi'a Islam and the Bahá'í faith puts these groups in a difficult position with regard to their religious practices and their daily lives. Some Egyptian Sunnis question whether Shi'as are real Muslims; this stereotype persists in spite of some attempts by al-Azhar University, a leading Sunni institution in Egypt and the Muslim world, to bring Sunnis and Shi'as together.

In January 2012, Egyptian authorities reportedly closed the Shi'a Husseinia mosque in Cairo to prevent Shi'a Muslims from observing the annual Ashura rituals. The mosque had only just been opened. Shi'as are forbidden from building their own religious places where they can practise their beliefs. There were no Shi'a representatives in the Constituent Assembly. In addition, there have been media attacks on Shi'as by some Salafist TV channels (Salafists are a strictly orthodox Sunni Muslim sect, which advocates a return to the early Islam of the time of the Prophet and the first four Caliphates).

Mohamed Afour, a Shi'a teacher, was sentenced to a year in prison after having been arrested while reportedly practising his Shi'a rituals in a mosque. The Egyptian Initiative for Personal Rights said that he was sentenced because of his faith. The state continues to apply discriminatory measures against Shi'as, while leaving the community exposed to the growing danger of Salafi extremism, according to Ahmad Rasem El-Nafis, a prominent Shi'a scholar. According to El-Nafis, the Egyptian authorities do not offer adequate protection.

Bahá'is were previously not eligible to obtain identity cards because the only options under 'religion' were Muslim, Christian or Jew. But in 2009 a court allowed Bahá'is to leave the field empty. However, many of them have yet to receive identity cards, and this affects their daily lives, regarding matters such as inheritance, legal marriage and pensions.

With regard to women, sexual harassment continued without any serious steps by the government to stop it. For example, in June, at least six Egyptian and foreign women were sexually assaulted in Tahrir Square, Cairo. On rare occasions, cases were referred to the courts but there have been no prosecutions of those who committed these acts. The only military officer

who was tried for sexual assault of some female protesters was acquitted by a military judge.

Moreover, an article guaranteeing equality between men and women was removed from the 2012 Constitution, although there is provision for equality before the law without discrimination and an article that says that the state shall guarantee coordination between the duties of the woman and her public work. It will also provide protection and care for divorced and widowed women.

With regard to Nubians, activist Manal al-Tiby was the representative for Nubians in the Constituent Assembly, but she withdrew her membership in September 2012 in protest against what she described as the domination of Islamists in the drafting of the Constitution. The new Constitution makes no mention of Nubians as a distinct ethnic group. Tens of Nubians held demonstrations against selling land that they claim is ancient Nubian property. The government replied that development projects in this area were planned to benefit the Nubian community. 'Nubians want full citizenship, where their history is celebrated and taught in schools' curricula, going back to the land around the lake, naming the lake (currently called Lake Nasser) Nubia Lake and having a say in the development plans in their region,' according to writer and activist Fatma Emam. Emam was referring to the mass relocation of whole Nubian communities in 1964 to make way for the Aswan High Dam on the Nile.

Iran

Iran has many minorities, including Ahwazi Arabs, Azeris, Bahá'is, Baluchis, Christians and Kurds. Activists and members of those groups continued to face discrimination and marginalization by the Iranian authorities. Representatives of Iranian minority groups expressed their frustration and disappointment at the regime because it deprives them of their rights, including those mentioned in the Constitution. In 2012, the Iranian government did not allow the UN Special Rapporteur on human rights in Iran, Ahmed Shaheed, into the country to investigate the human rights situation. Shaheed urged the Iranian government to end discrimination against women as well as

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Case study by *Sarah el Ashmaouy*
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Egypt: Nubian community health support systems

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The opening of a new hospital in Aswan only underlines the government's long-term neglect of the health needs of Nubians.

In January 2011, then President Mubarak inaugurated the new Aswan hospital; Aswan is the capital of Nubia in Southern Egypt. Meanwhile, in Cairo, the Nubian community had organized a support system for members of their community who need to access health care that was not available in Aswan. Each of the 22 villages of the Nubian region collected money to rent or buy a modest space in Cairo where inhabitants of the same village could stay while receiving health care in Cairo. This was coordinated through the Nubian club, which was created to maintain the cohesion of the Nubian community in Cairo and has an apartment in Tahrir Square for Nubians to meet and seek support if facing any troubles. The Nubian club was thus at the heart of the self-created health care support system.

This self-support system is a symptom of the problem of health care in Egypt, particularly in the peripheries of the country like Nubia. Despite the efforts of the Nubian community in Cairo to help Nubians living elsewhere to access services, the quality of health care accessed in Cairo by Nubians depends on their income and resources, which are usually among the lowest in the country. To tackle this, Cairo Nubians have consolidated networks of

individuals inside hospitals and medical centres who are willing to help Nubians in dire need of health care. But the problem remains bigger than the action of individuals.

There is a long history of government neglect of Nubians in Egypt. Many Nubians were forced to leave their land to make way for the

Below: Nubian children in Aswan, Egypt.
Ry Tweedie-Cullen.



Case study continued

construction of the Aswan Dam in the 1960s. The government promised compensation and shelter; however, the resettlement plan offered poorly designed buildings for Nubian families. There were very few employment opportunities in the urban 'new' Nubia, and as a result many Nubians moved to Cairo for better education and employment opportunities. Nubians had little or no access to basic services

The Aswan hospital is the only one in the new Nubia to serve the 22 villages of the Aswan governorate. The eight medical centres scattered around new Nubia are difficult to access, lack basic medical equipment and often have no personnel. In some places, Nubians have to travel 44 km to access their closest medical centre, some of which are not even equipped to treat injuries or deliver babies. The lack of the simplest equipment, such as antidotes for scorpion bites or dialysis machines, has led to deaths from diseases which are easily preventable. The Aswan hospital, for example, only has two dialysis machines, one of which is not functional.

This is not only due to the poor health care policies of the Egyptian government but also the lack of reliance on local resources. Doctors from Cairo who work in the hospital leave Nubia three days a week to go back home, while Nubian medical students pursue their careers in Cairo. Nubians have frequently addressed their local governor, demanding better social services, including health care. Each time, their demands have been met with a promise of policy change, followed by a 'bureaucratic' excuse that refers the action back to the Cairo cabinet.

Lost in the pile of files referred back to the Cairo cabinet, the lack of action on the issue of health care in Nubia has left Ahmad, an 11-year-old boy from Aswan who suffers from epilepsy, no choice but to travel to Cairo. Here he hopes to find an Egyptian doctor who will finally sign a form that will enable him to access health care in Cairo, rather than the Aswan hospital, which cannot provide him with the care he needs. ■

ethnic and religious minorities. While there are mechanisms in Iran for respecting human rights, violations are reported in the testimonies of 221 individuals collected between November 2011 and July 2012, according to Shaheed. Minority languages are prohibited in both government institutions and as subjects to be taught in schools. Schools in minority regions are very poor and the rates of drop-out and illiteracy are higher in those areas than the national average, according to the Baluchistan People's Party.

Dozens of Ahwazi Arabs have been detained, tortured and executed since demonstrations broke out in Khuzestan province in April 2011. The year began with security round-ups in the region, leading to the arrest of at least 65 people. Twenty-seven Ahwazi Arab residents of Shush in Khuzestan were arrested because of their alleged involvement in a campaign to boycott the March parliamentary elections and expressing support for the 'Arab Spring'. In June four Ahwazi Arabs, including three brothers, were executed on charges of 'enmity against God', after having been accused of killing a law enforcement official. Family members disputed the charges. They had been arrested during demonstrations in the province of Khuzestan. In July 2012, five Ahwazi Arabs were sentenced to death and a sixth received a 20-year prison sentence. International human rights groups contested the charges and argued that they were arrested because of their connection to demonstrations in February and March 2011 ahead of the sixth anniversary of protests by Ahwazi Arabs in 2005 calling for a better life for their people. According to the Unrepresented Nations and Peoples Organization (UNPO), a total of nine Ahwazi Arabs were awaiting execution by October, after further capital convictions later in the year.

Ahwaz city was rated as the most polluted city in the world by the World Health Organization (WHO) in 2011 and the rate of asthma among children there has long been higher than the regional average. Life expectancy is the lowest in Iran. A critical issue is the prevalence of particles smaller than 10 micrometres (PM10), since these penetrate deep into the lungs and the bloodstream. The WHO recommends a limit of 20 micrograms of PM10 per cubic metre of air; Ahwaz city records 372 micrograms.

Heightened health risks from such intense air pollution include cancer, hypertension, diabetes and birth defects. Causes include desertification resulting from river diversion and the draining of marshes, as well as petrochemical and other industries located in the area. In *State of the World's Minorities and Indigenous Peoples 2012*, MRG analysed the connections between natural resource extraction, land rights and discrimination against minorities, including a case study on Iran.

Ahwazi Arabs complain of being forced out of the oil-rich province of Khuzestan in order to replace them with majority Persians. In addition, the authorities consider their call for equality as a threat to national security. According to the Ahwaz Human Rights Organization, they are not allowed to teach their native language, and this violates the Iranian Constitution as well as the international human rights norms. The government also prohibits Arabic-speaking Iranians to name their children with non-Shi'a Arab names. The use of minority languages in schools and government offices

Below: Ahwazi Arab man and child, Iran.
Alan Rempfer.

is generally prohibited, according to Amnesty International.

While Khuzestan is a rich province on account of the large-scale oil production, the area suffers from poverty and a lack of adequate social services. In addition, the towns of Bostan, Dashte-Azadegan and Hovazeh have inadequate access to health care centres and are subject to frequent deaths because of untreated accidents. The Dashte-Azdegan region has the highest rates of child malnutrition, according to the Ahwaz Human Rights Organization.

Kurds also face persecution in Iran. Journalist and founder of the Human Rights Organization of Kurdistan Mohammad Sadiq Kabudvand went on hunger strike in May and July, according to Amnesty International; he had been denied access to his seriously ill son and was himself refused medical treatment. In June, Mohammad Mehdi Zalieh Naghshbandian, a Kurd, died in Rajaei Shahr prison because of inadequate medical attention by prison officials. Three Kurds were



executed in September in Oroumieh, after having been found guilty of illegal political activities.

The situation is also difficult for the Baluch minority. Public demonstrations or acts of violence by extremists provoke a harsh government response. In October, three men were hanged in Zahidan prison, a few days after a suicide bombing in Chabhar. The three men were not connected to the bombing incident – rather their executions appeared to be intended as a signal from the government that acts of defiance would not be tolerated. One was reportedly a teenager. The Baluch People's Party noted that 11 political prisoners were awaiting execution in October. MRG has previously reported how the Baluch minority are caught in the struggle between armed insurgents and the Iranian authorities, with violent acts by the former serving as a pretext for further militarization and repression by the latter.

Women face discrimination in a number of areas, especially with regard to family law. A number of women's rights activists remained imprisoned in 2012. One of them was released in November after spending 1,622 days in a detention centre, according to the International Campaign for Human Rights in Iran and Campaign for Equality. Zainab Bayazidi, a member of the Campaign for Equality (previously called the Campaign for One Million Signatures to Change Discriminatory Laws in Iran), was arrested and sentenced to imprisonment because of her work challenging inequality. Bayazidi has also been active in the Human Rights Organization of Kurdistan. In addition, 36 universities across the country banned female enrolment across certain subjects, and set quotas limiting the number of women on other courses as well as enforcing gender segregation in their institutions.

The persecution of Bahá'is by the government intensified during the year. Human Rights Watch (HRW) noted a crackdown on the community in Semnan, leading to the closure of at least 17 businesses. Amnesty International reported that at least 177 Bahá'is were detained for their religious beliefs during 2012. Seven Bahá'i leaders continued to serve 20-year prison terms after their arrest in 2009, despite vocal international protests.

Iran officially recognizes three non-Islamic religious groups – Zoroastrians, Christians and Jews. During the autumn, Christian pastor Youssef Nadarkhani was released after having been jailed for nearly three years for his beliefs in 2012. He was acquitted of apostasy, but was convicted of evangelizing to Muslims. He was subsequently re-arrested in December and then released once more in January 2013. Religious minorities are not allowed to proselytize and there are restrictions on published religious materials. In January 2013, Saeed Abedini, an Iranian-born American pastor, was sentenced to eight years in jail for establishing Christian house churches; he had been arrested in September. In September 2012, the UN Special Rapporteur on human rights in Iran reported that at least 300 Christians have been arbitrarily arrested and detained since June 2010.

Iraq

It has been a decade since the US-led invasion of Iraq in 2003. The sectarian conflict between the Shi'a and Sunni communities has escalated, and tensions between different groups have grown. The sizeable Sunni population accuses the government of Shi'a Prime Minister Nouri al-Maliki of marginalizing them. Everyone in Iraq is exposed to attacks and violence, and the resulting deaths and injuries have blighted Iraqi daily life. According to the UN Assistance Mission to Iraq (UNAMI), the number of civilian casualties rose to at least 3,238 reported deaths in 2012, compared with 2,771 the year before (other sources reported higher figures). The year 2012 was the first since 2009 in which the figures had increased. The escalation continued beyond year's end; May 2013 witnessed the bloodiest month of violence since June 2008, in which 1,045 Iraqi civilians and security officials were killed.

The cycle of violence affected Shi'a and Sunni groups, as well as smaller minority communities. Shi'a Muslims experienced the worst attacks of any religious community in 2012, with pilgrims celebrating religious festivals especially targeted. In January 2013, Shi'a pilgrims were targeted by insurgents who killed and injured hundreds. In May, Sunni mosques and areas were attacked, which resulted in the killing and injuring of

hundreds. And in August, a leading Sunni cleric, Sheikh Mahdi al-Sumaidaie, was seriously injured and four of his bodyguards were killed in an attack on his convoy; the attack occurred after the sheik had celebrated the beginning of the Eid al-Fitr holy day. He had urged all Iraqis to renounce violence and work together.

Tensions between the Shi'a and Sunni communities escalated after the fugitive Iraqi vice-president, Tariq al-Hashimi, was sentenced to death *in absentia* in September allegedly for orchestrating terror attacks on officials and security forces. Hashimi was the most prominent Sunni politician in the country. The Shi'a holy day of Ashura in November passed peacefully, albeit following a string of car bombings just before. Only days after, at least 40 Shi'as were killed in attacks in Baghdad and southern Iraq. In March 2013, the tenth anniversary of the US invasion was marked by a series of attacks in Shi'a areas that killed nearly 60 people.

Smaller minority communities also faced attacks. According to UNPO, two Turkmen teachers were found dead in December near Humera, south-west of Kirkuk; both bodies bore

Below: A Sabean Mandaean bride participates in a wedding ritual, Iraq. *Shiho FukadalPanos.*

signs of having been tortured. In January 2013, a tent full of Turkmen mourners in Tuz Khurmato was struck by a suicide bomber; at least 35 people were killed and over 100 were wounded.

Ethnic and religious minorities have been targeted in Iraq since 2003. The fact that minority communities do not have the protection of militias makes them more vulnerable to kidnapping for ransom; nor do they get the necessary protection from the authorities. Bomb attacks and suicide bombings have been used in areas where minorities live. Large numbers of the smaller religious communities, including Christians, Sabean Mandeans and Yezidis, have left the country. Violence has even reached the Iraqi Kurdistan Region, which has been safer than the rest of Iraq. Reports of sectarian violence were fewer there than elsewhere, although religious minority communities noted cases of arbitrary detention, harassment, discrimination and threats by officials of the Kurdistan Regional Government (KRG). Some members of minority





groups wear veils or hide their religious symbols to avoid being targeted. According to Christian women in Iraq interviewed by MRG, social pressures and the increasing sectarian tensions lead them to keep a low profile.

Christians continued to flee the country. The current population is believed to be less than half its pre-2003 size. Some were reportedly forced to sell their homes to militants at cheap prices. Christians had previously fled Baghdad for the comparative safety of the northern provinces. The flight north was especially marked following the large-scale attack on Our Lady of Salvation Church in Baghdad in 2010, which left 56 Christians and 2 priests dead. Dwindling resources, lack of employment prospects and a sense that the violence is coming closer led Christian displaced to decide finally to leave the country. For example, in May, 20 Christian families reportedly fled Mosul after receiving threatening letters calling on them to leave their

homes. A controversial amateur internet video launched in September sparked a wave of such death threats by militant groups. In addition, several Christians were killed or kidnapped, and churches were attacked during the year. A radical group attacked a church in Dohuk in May and looted some of its contents. In September, the Chaldean Catholic Sacred Heart Cathedral in Kirkuk was hit by a bomb blast; there were no casualties. Although the building may not have been the intended target, the attack added to a general sense of vulnerability. A local human rights group reported three other attacks on churches in the city during the year. It was estimated that only 25,000 Christians now live in Mosul while their number was 75,000 in 2003.

Other minorities were attacked, such as the killing of a Yezidi and his wife in Sanjar district north of Mosul and a Shabak person in Nineveh by militants. In December, a

Left: A Shi'a Muslim girl takes part in the Ashura festival, Saudi Arabia. *REUTERS/Zaki Ghawas.*

Sabeen Mandaean goldsmith was killed in his shop south of Baghdad. Moreover, 20 graves belonging to Sabeen Mandaeans were attacked in Kirkuk. A local human rights organization tallied the following serious attacks on members of minorities: 5 killings, 5 kidnappings and 12 murder attempts against Christians; 2 killings and 4 kidnappings against Yezidis; 2 killings of Sabeen Mandaeans; and 26 killings of Shabaks. There were other less serious attacks, as well as incidents that went unrecorded.

There are inadequate health facilities in areas where many minorities live. A key issue during the year was the prevalence of suicides among minorities. There were, for example, about 50 suicides in the city of Sinjar, mainly inhabited by Yezidis. The UN is planning a sensitization campaign in schools in order to train teachers and pupils about the issue. Among the main reasons for these tragedies were dire poverty and failure to get asylum abroad. Other minorities have also witnessed increases in the suicide rates.

Some Iraqi women, including those who lost their husbands in the armed conflict, have experienced financial problems and have been sexually exploited. Those displaced, including women belonging to minorities, face serious risk of abuse by people smugglers. While the parliament passed a law in April to tackle trafficking, enforcement remains a serious problem faced by women who are vulnerable to sexual abuse.

There is a need to reform the educational curriculum to reflect the variety of different communities and encourage tolerance. A minority alliance worked during the year with the Ministry of Education to bridge ethnic and religious divides through education. The alliance reviewed the material provided to children studying at the intermediate level and made recommendations. Many of these were accepted and the revised textbooks were distributed to schools in September 2012. A key recommendation was that Iraqi children needed to learn more about the wide range of minorities in their country and their contributions to its history and culture.

Saudi Arabia

Although King Abdullah made some efforts at reform in 2012, restrictions remain tight for women and non-Sunni Muslims. Saudi law neither recognizes nor protects freedom of religion. In addition, restrictions on those freedoms have been implemented by the religious police or Muta'ween.

Shi'a Muslims comprise 10–15 per cent of the population in Saudi Arabia. The majority of the population are Sunnis who follow a strict Wahhabi interpretation of Islam. There is also a small number of Christians who are largely expatriates, and also Hindus, Buddhists, Sikhs and others.

The majority of Shi'as live in the country's Eastern Province, especially in al-Ahasa and al-Qatif. Human rights groups say there is systematic discrimination against Shi'a Muslims in education, employment and justice. Shi'as are also under-represented at the higher levels of government.

Members of Saudi Arabia's Shi'a community have repeatedly protested in the wake of the 'Arab Spring' in 2011, calling for their rights to be respected. According to HRW, the Saudi security forces have killed 11 Shi'a protesters since 2011, while other sources report somewhat higher figures. Al-Qatif has witnessed a number of demonstrations in support of Shi'as in Bahrain and calling for reforms to their own situation, which is characterized by discrimination and marginalization. Hundreds of Shi'as were arrested during 2012, particularly in the Eastern Province, in connection with protests. While many have been released, some 180 protesters remained in detention at year's end. Demonstrations also resulted in violence, causing injuries as well as deaths. The detention of the influential Shi'a leader Sheikh Nimr Al-Nimr led to an increase in protests and resulting violence. Al-Nimr was arrested in early July because of his statement that Shi'as should be respected and live in dignity, otherwise the Eastern Province should secede. Four men were killed in the demonstrations that followed the Sheikh's arrest – three died during protests immediately after El-Nimr's arrest and a fourth was killed five days later in al-Awamiyah.

Further arrests in the Eastern Province led to short-term detentions and concerned Shi'a

religious practice. The only explanation given was usually that these were in connection with private worship. It seemed as if these detentions were primarily in areas where the population is more evenly split. Where Shi'a Muslims represent a local majority, there was apparently some improvement in the possibilities to pray publicly.

Recently, the Saudi authorities arrested some Shi'a Muslims and charged them with spying for Iran. Shi'a Muslims insist that they are innocent and that there is only a spiritual link between them and Iran.

Although King Abdullah has sponsored dialogues with religious groups, there is no freedom of religion for non-Sunni Muslims. Public expression of Christianity and other non-Muslim religions is banned. Mosques are the only public places of worship in Saudi Arabia, and the construction of churches, synagogues or other non-Muslim places of worship is not allowed.

In addition, the 35 Christian Ethiopians who were detained in December 2011 for 'illicit mingling' during a private religious service were deported in August. The detainees claimed that they were arrested because of their Christian faith, and several human rights organizations reported that the police interrogation was mainly about their faith. Twenty-nine of the Ethiopians were women, and they were subjected to strip searches.

In February, Hadi al-Mutif was released after 18 years behind bars. He was convicted of insulting the Prophet, although according to HRW the judges showed bias in the conduct of al-Mutif's case on account of the fact that he belongs to the minority Isma'ili Muslim community. He was only freed after his repentance was accepted by the chief Mufti.

During 2012, the government school textbook reform project continued, resulting in the elimination of some intolerant messages, but discriminatory language remains. Some content still justifies the exclusion and killing of Muslim minorities and those deemed to be 'apostates', while Christians and Jews are reportedly described as violating monotheism.

Women's rights

Although King Abdullah has made some reforms, many restrictions on women remain. In January 2013, King Abdullah appointed 30 women to the

all-male Shura Council (Consultative Assembly) for the first time. There is still separation between the two sexes inside the Council and they have to speak through a communication system and enter through special gates; but it is a step that should be welcomed. The Council will also have four Shi'a members and one of them is a woman. Women will also have the right to vote in 2014 municipal elections. According to HRW, women are banned from travelling or going through medical procedures without permission from their male guardians. For example, in July an operation for a woman was postponed at the King Fahd hospital because her male guardian was not there to authorize it. In addition, there was controversy surrounding the news that male guardians were receiving automatic text messages when their female dependents crossed the borders of the country.

In March two women-staffed police stations opened for the first time in Jeddah and Riyadh to encourage women to use police facilities. However, violence against women continues to go unpunished. In May a court convicted a man who assaulted his wife, but it was a lenient sentence: to learn by heart five parts of the Qur'an and 100 sayings of the Prophet Muhammad.

Syria

Atrocities and violence since March 2011 have turned the uprising in Syria against the Bashar al-Assad regime into a prolonged crisis. The continuous fighting between the army and armed opposition groups had resulted in the deaths of around 93,000 people by spring 2013. By the end of 2012, 750,000 had fled across the country's borders, and there were well over 2 million internally displaced. In February 2012, the UN High Commissioner for Human Rights, Navi Pillay, warned that the situation in Syria had 'reached horrific dimensions', describing the situation as 'an intolerable affront to the human conscience'.

There are different groups within the political and armed opposition. The opposition is supported by several countries, such as Qatar, Saudi Arabia and Turkey. In June 2013, the US announced that it would provide direct military support to the opposition; the European Union (EU) lifted its arms embargo the month before.

The regime is backed by Iran, Russia and the Hezbollah organization in Lebanon. So far no solution has been proposed to end this conflict. Some minorities, such as Christians and Alawites, have been targeted, because they are believed to support the regime. Sectarian divides have grown in Syria between Sunnis, Alawites, Christians and Druze, especially since 2012 according to UN reports and refugees interviewed by MRG.

The UN commission of inquiry also warned that the fighting increasingly has a sectarian aspect. Regime troops and pro-government militia have committed massacres, according to the commission. At checkpoints and detention centres, government forces have committed murder, torture, rape and enforced disappearances following arbitrary detentions. In its February 2013 report, the commission noted a disturbing pattern, namely the shelling by government forces of whole neighbourhoods, with bread lines and hospitals being particularly targeted. Opposition armed forces have also been guilty of murder, torture, hostage-taking and arbitrary arrests. While the offences are grave on both sides, the commission noted, the scale of attacks on civilian populations was far greater from the government side.³ Citing local activists, HRW reported that at least 865 detainees had died during 2012 while in government custody.

At the beginning of the uprising, anti-Christian and anti-Alawite slogans were reported. Some opposition groups have banned such chants. However, there are concerns that the divisions among different groups in Syria may well be deepening.

President Assad belongs to the minority Alawite group and relies on Alawite support to stay in power, backed by certain members of other minorities, especially Christians and Druze, plus a select group of Sunni majority businessmen. Alawites comprise about 10 per cent of the population, Christians, about 10 per cent, while about 70 per cent are Sunni Muslims. Druze, a community whose faith emerged from Isma'ilism and Shi'a Islam, make up 4–5 per cent of the population; they have generally avoided taking sides in the current conflict. While a few Druze have aligned themselves, the majority have stayed neutral and have established checkpoints and militias in their areas, especially Suwaida,

southern Syria, where Druze mainly live, in order to protect their people. Some Druze have been involved in fighting against armed militant groups, such as Jabhat al-Nusra (an al-Qaeda linked group). There were kidnappings and an attack on a Druze village in early 2013.

There are growing concerns that Alawites could be the main target of discrimination if the regime collapses. Some protesters associated the whole Alawite community with the Assad regime; as a result, Alawites were particularly targeted in reprisal attacks during 2012. Several international human rights organizations, including Amnesty International, called for the protection and safety of minorities in Syria, especially those suspected of backing the Assad regime, by any future government. In this context, Adama Dieng, the UN Special Adviser on the prevention of genocide, urged all parties to the conflict to adhere to international humanitarian and human rights law, especially those provisions which prohibit the targeting of individuals or groups based on religious or ethnic identity.

Kurds are denied their basic rights. They represent about 10 per cent of the Syrian population. Their language is not recognized and is not taught in schools. In addition, Kurds who could not prove their residence in Syria from 1945 onwards were denied their Syrian nationality according to Law 93 of 1962. About 300,000 Kurds do not have citizenship and are stateless. This puts pressure on their daily life in employment, travel and marriage. It should be noted that President Assad issued a decree to grant citizenship to Kurds living in Hasaka in 2011.

Towards the end of 2012, there were reports of fighting between the opposition Free Syria Army and Kurdish fighters linked to the Democratic Union Party (PYD), raising fears of a power struggle. Kurds have otherwise kept their distance from the fighting to avoid being targeted. Kurds have set up checkpoints along the main road of Qamishli, the unofficial capital of the Kurdish area. The lack of government presence in the Kurdish areas has given them more freedoms and they have started teaching the Kurdish language, which was forbidden before the March 2011 uprising. By assuming responsibility to keep security in their region, a cultural renewal has been made possible, with Kurds now able

to speak their language freely. But this has not meant that the Kurdish region has been isolated from the conflict. According to media reports, schools have been closed and medical assistance has been hard to come by. There have also been government air strikes against the region.

Shi'a Muslims also faced difficulty in 2012. For example, according to HRW, a Shi'a place of worship in Idlib was destroyed by opposition forces towards the end of the year. Shi'as living in Zarzour were displaced from their village, because they were seen as supporters of the regime.

Harassment of Christians reportedly increased during 2012. Government forces raided the Syrian Orthodox Um al-Zennar Church in Homs in February, leading Christians to join protests in greater numbers in that city. In May, security forces arrested worshippers gathered at St Cyril's Cathedral in Damascus to remember a deceased opposition activist. Christians left their homes in the villages of Ghasaniyeh and Jdeideh in Latakia governorate for fear of the opposition forces, as well as the urgent humanitarian situation, and worries about government air strikes and shelling. Two churches were reported to have been looted in December.

Some Christians have reportedly left their homes because they do not have a militia to protect them from attack. Some churches have been set on fire. A local priest told a BBC journalist that some young and unemployed Christians have come under pressure from the regime to defend themselves. They were told that armed militant groups were going to kill them. It should be said that many Christians have refused to be armed. Some arrangements between Christian activists and opposition forces were struck not to target the Christian areas.

Tunisia

The Jasmine Revolution in Tunisia opened the door to other countries in the region to change their regimes. The first free elections after the ousting of President Zine El-Abidine Ben Ali took place in October 2011. The moderate Islamist Ennahda party, led by Rashid El-Ghanoushi, won a majority in the National Constituent Assembly along with two smaller coalition parties.

At the time of publication, the Constitution

Case study

Christians in Syria

Fears for Syria's ancient Christian communities continue as they are attacked by both the militias and government forces.

The Syrian Christian community makes up approximately 10 per cent of the population, but its size has been declining since the March 2011 uprising due to displacement and emigration. There are Greek Orthodox, Greek Catholic, Syrian Orthodox, Syrian Catholic, Armenian Catholic, Assyrian and Chaldean Christians. The number of Syrian Christians abroad is about 5 million, although this number is rising due to displacement and emigration.

Syrian Christians have their own courts that deal with marriage, divorce and inheritance. Damascus contains a sizeable Christian community.

The plight of Christians in Syria was articulated by eyewitnesses, journalists and religious leaders. For example, a Syrian refugee in Lebanon said that Christians have no guns while they have been attacked by both armed militias and the government. A Catholic charity representative said that many Christians feel they have to support Assad because they fear what may happen if the rebels win: they may face the same tragedy as Christians in Iraq. Church leaders express fears that Syria may lose its Christian minority. Emigration has increased. Some sources reported increased intolerance and employment discrimination as key reasons for Christians choosing to leave. Churches and Christian institutions, such as schools and hospitals, have been destroyed. Neither the government forces nor the opposition militias admit those attacks. According to the Archbishop of the Syrian Orthodox Church, Yohanna Ibrahim, some churches have been closed because of the ongoing fighting. The number of worshippers has declined by over

50 per cent because of security issues, except in the areas that have Christian majorities and where security arrangements can be made. The Archbishop noted in spring 2013 that more than 30,000 Christians had fled Aleppo and more than 6,000 Armenians had left for Armenia, while more than 300,000 Christians were internally displaced by then.

In Syria, caution and fear now characterize relations between the different elements of society. Each community is cautious when dealing with other groups. Alawites left Aleppo

out of fear; Shi'as also fled the region for the same reason. And Christians are now on the move in order to avoid increased intolerance, targeting by militant groups, the threat of government bombardment and the increasingly dire humanitarian situation. ■

Below: The Um al-Zennar Church was damaged during clashes between Syrian rebels and the Syrian government in Homs, in 2012. REUTERS/Yazen Homsy.



remained in draft form. The prime minister was chosen from the Ennahda party, first Hamadi al-Jabali and then Ali Larayadeh. Some government policies have been heavily criticized, such as the apparently lenient handling of members of the radical Salafist movement who have attacked activists and intellectuals without being charged for their actions. In this context, Chokri Belaid, head of the opposition Democratic Patriots Party and a critic of Islamist parties, was assassinated in February 2013. While there have been reports of arrests, it is not yet known who committed this crime. Drafts of the Constitution raised concerns. There were demonstrations against Article 28 of the first draft, which stated that women and men's roles 'fulfil each other', while not explicitly affirming equality between the sexes. Draft Article 3 was criticized since it allowed for the criminalization of religious offences, with the risk that it would pave the way for restrictions on freedom of expression. In January 2013, HRW noted that the second draft had brought several key improvements. It did express concern, however, about draft Article 15, which gave greater weight to national legislation than to international human rights treaty obligations. The organization also worried that judicial independence was insufficiently protected. Finally, it noted that only Muslims could become president, a provision that contradicted a general equality clause.

Tunisia has small minority communities. The estimates for the size of the Berber community vary from 1 to 2 per cent of the population. There are also small Jewish, Bahá'í and other religious minority communities.

Islam is the only religion taught at public schools, but history as taught in public secondary schools also covers the history of Judaism and Christianity.

Attacks by members of the Salafist movement were an increasingly worrying tendency, especially since the authorities appeared to do little to bring the perpetrators to justice. Journalists, artists and human rights defenders were among the targets. In August, for example, a group of men attacked a festival to commemorate the international day for Jerusalem in Bizerte, north of Tunis, and at least three activists

were injured. The men reportedly accused the organizers of being Shi'a Muslims.

Jews have been under pressure since the departure of the ousted President Ben Ali. There have been occasions when members of the Salafist movement have shown hostility to the Jewish community. For example, during the January visit of Ismail Haniyeh, the prime minister of the Hamas government in Gaza, a group of Salafists shouted, 'Kill the Jews. It is our religious duty.' The slogan was condemned by Ennahda party officials. In this context, the Tunisian Association to Support Minorities sued Sheikh Ahmad Al-Suhayli of Rades for hate speech against Jews, following a sermon that was broadcast live in November on Hannibal TV. The lawyer who represented the association argued that the sermon violated the 2011 Decree 115, which criminalizes calls for hatred. Throughout 2012, there were repeated media reports that members of Tunisia's Jewish community were expressing unease about the new political order and the impunity apparently enjoyed by religious extremists. At the same time, President Moncef Marzouki attempted to send a reassuring message when he visited the historic El Ghriba synagogue on the island of Djerba at Passover. The visit was significant on many levels, not least since Passover in 2012 marked the tenth anniversary of a suicide bombing at the synagogue that killed 21 people. And the Jewish community received support from the authorities when an event organized by the prominent Islamist cleric Youssef al-Qaradawi was relocated from the island of Djerba to Tunis. The gathering was supposed to have been held four days before the annual Jewish *hiloula* (or pilgrimage) to the island during the Lag Ba'Omer holiday, and there were fears of something going wrong. The pilgrimage went ahead as planned. While 500 people came on the 2012 pilgrimage compared with 5,000 in 2010 (it was cancelled in 2011), the turn-out was still viewed positively by the community.

Jews have lived in Tunisia since Roman times. Jewish influence can be found in music, culture, names and other aspects of life in Tunisia. Their number exceeded 100,000 after the Second World War, but currently fewer than 2,000 Jews live in Tunisia, and about

half of the community lives on Djerba. It is the second biggest Jewish community in the Arab world after Morocco. Debates about the community's future have been ongoing but intensified in November, after the police arrested five Tunisians in Zarzis for allegedly planning to kidnap Jews belonging to wealthy families to get a ransom.

Jews in Tunisia reportedly feel a need to maintain a low profile. For example, Jewish men generally do not wear the *kippah* (the Jewish male head-covering). Haim Bittan, the chief rabbi of Tunis, noted in an interview that Tunisian Jewish men wear a hat instead of the *kippah*. He explained, 'People might think we are Zionists and we do not want that, so we wear a hat.' There are no laws that restrict the wearing of the *kippah*, but the rising influence of the Salafist movement and fears that the head-covering or other Jewish symbols may be misinterpreted are the main reasons cited for being cautious. This is of course hard on practising Tunisian Jews since they feel a religious obligation to wear the *kippah* or other Jewish symbols. While *The Economist* magazine reported that the Tunisian authorities strengthened security for the spring 2013 *biloula*, it noted that pro-Palestinian graffiti simultaneously appeared on government buildings in Tunis.

Nevertheless, the few Jews who remain in Tunisia are generally unwilling to leave. While Silvan Shalom, Israel's deputy prime minister, called on Tunisian Jews to leave the country in December 2011, the reaction from the community was largely negative. A BBC reporter interviewed Jacob Lelouche, who runs the last kosher restaurant in Tunisia. Lelouche expressed his opposition to leaving, since he felt safe.

Most Christians are foreigners, but there are some converted Tunisians. While it is difficult to get a comprehensive picture of this group, MRG interviewed a Tunisian Christian convert in February 2013 who described how he had felt so threatened that he had decided to leave the country. The Tunisian Association to Support Minorities documented that a Salafist attacked the Russian Orthodox Church in Tunis and broke its crosses. The suspected person was arrested. ■

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Case study by *Hanan Hammoudeh*
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Palestinian refugees in Lebanon

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The poor conditions in the camps in Lebanon where Palestinian refugees have been living for more than 60 years lead to chronic ill health and mental health problems.

'[Health issues] are a result of the pressures of life, poverty, the lack of movement, the electricity, the water, and the overcrowding.'
Ahed Khalil, aged 22, Burj el Barajneh refugee camp resident.

Often calling themselves 'forgotten people', Palestinian refugees make up 10 per cent of the population of Lebanon. Facing marginalization and discrimination, these residents are without basic human rights. Besides their lack of political and civil rights, they are denied access to public health care and largely depend on aid and the charity sector for health provision. Today, most of these refugees live in camps and locations that are characterized by water contamination, where health risks are exacerbated by overcrowding. Meanwhile, laws prohibit the expansion of the camps. A peek into the life of the camps illuminates the intersection of marginalization, social exclusion, poverty, and the consequent health impact among the present minority.

Doctor visits and hospital care

On average, a doctor at a health clinic run by the United Nations Relief and Works Agency (UNWRA) sees 117 patients daily. Hospital care is often inaccessible to Palestinian refugees due to high costs, and those in need of care often seek aid from charities and other people in order to pay hospital fees. Poor health is both a symptom and a cause of economic hardships among the refugee

Case study continued

community. An American University of Beirut report published in 2010, which took into account mental, physical, acute and chronic health issues, indicated that 57 per cent of households said they had made visits to a doctor or incurred medical costs resulting from chronic illnesses; thus chronic illness is the most common reason for receiving medical care. The most common of chronic illnesses was found to be hypertension, which was at a 32 per cent prevalence among Palestinian refugees with chronic illnesses, compared with 14 per cent among the Lebanese population. Overall, the study found a 31 per cent chronic illness incidence among Palestinian refugees, compared with the 17 per cent among the Lebanese population.

Health behind camp walls

According to the report, 66 per cent of Palestinian refugee camp homes were affected by leaks and dampness, with water leaking from every one in three ceilings. The report also indicated that higher illness prevalence was associated with some housing traits common to camp infrastructure. People who lived in homes that had asbestos, eternit, or wood in their walls had an astounding 100 per cent of chronic illness prevalence. Homes in which four or more people lived per room were associated with higher prevalence of functional disabilities and acute illnesses. Ahed, a 22-year-old resident of the Burj el Barajneh refugee camp in Beirut, described the overcrowding of the camps as '*nas fo' ba 'ad*', a figurative phrase in Arabic literally meaning 'people piled on top of one another'.

The Palestinian refugee population has double the prevalence of disability of the Lebanese population, despite no significant difference in birth defects, and 20 per cent of disability cases among the Palestinian refugee population are the effects of accidents. When describing the environmental factors contributing to poor health in the camps, Ahed referred to, '[T]he electricity. Old infrastructure and water pipes intertwined

with electricity wires ... Children are dying as a result of this.' Among these is Ahmad Yakoub, a Burj el Barajneh resident who was 14 at the time of his electrocution and subsequent death. Between the years of 2010 and 2012 in the Burj el Barajneh camp alone, an estimated 20 people lost their lives as a result of electrocution. At a minimum, one electrocution-related death in the camp is estimated to take place every 2–3 months.

Mental health and the political environment

With regard to mental health, 21 per cent of Palestinian refugees surveyed for the American University of Beirut study reported psychological problems, including distress, depression and anxiety. It was suggested that the stresses of the Lebanese civil war and lack of civil rights within the country have contributed to these burdens. Ahed said that the environment was a principal factor tied to the mental health issues among the camp population, caused by 'poverty, the lack of movement, the electricity, the water, and the overcrowding'.

Palestinian refugees in Lebanon have long been victims of political scapegoating. Due to Palestinian factions' role in the Lebanese civil war, the population has long been stigmatized and has been approached with defence rhetoric. Ahed says that the camps are approached from a security angle, and this has thwarted adequate responses to issues such as health. Deprived of basic rights due to claimed security measures and embedded fears of permanent settlement, the health predicament of Palestinian refugees continues. ■

Endnotes

1. Prior to going to press, President Morsi was removed from office in July 2013 by the Egyptian military.
2. In July 2013, interim President Adly Mahmud Mansour issued a decree outlining steps to be taken to revise the 2012 Constitution.
3. See OHCHR, 'UN commission of inquiry: all parties becoming increasingly reckless with human life as the Syrian conflict drags on', retrieved July 2013, <http://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=13003&LangID=E>

Reference

Peoples under Threat 2013: Civilian protection and military intervention

Mark Lattimer

Introduction

Foreign news reports of a whole community under violent attack in another part of the world quickly prompt the reflection: what should we do? In the western media, the question is rarely posed without quickly leading to calls for armed intervention. No matter which other potential responses are tried – diplomatic pressure, sanctions, international prosecutions – the failure to intervene militarily inevitably invites the judgment: ‘We did nothing’.

The 2013 release of the *Peoples under Threat* index highlights the need to question this set of

assumptions in at least two important aspects.

Firstly, in those country situations of most concern in 2013, where the threat of genocide or mass killing is greatest or is rising most quickly, foreign military intervention is not the exception but the norm. Whether it be the deployment of a multi-lateral force under the auspices of NATO, the African Union or the UN, a military intervention launched by a foreign government or governments, or the arming and logistical support of proxy militias by neighbouring or interested states, the great majority of countries where the threat of mass killing is acute or killing is ongoing have been subject to armed intervention, in some cases on several occasions going back a decade or more.

Secondly, there is a complex causal relationship between civilian security and armed intervention in practice. While it is possible that foreign military action may halt an episode of mass civilian killing or decrease its intensity, it may also prolong or intensify killing, or even initiate a conflict where there was none before. In some cases, it may end one conflict, but start another; or have the effect of shifting violence away from one people or population group onto another or others.

Major Risers since 2012

Rank 2013	Rise in rank since 2012	Country	Group	Total
5	1	Pakistan	Shi'a (incl. Hazara), Ahmadiyya, Hindus and other religious minorities; Baluchis, Mohhajirs, Pashtun, Sindhis	20.42
6	8	Syria	Political targets, Shi'a/Alawites, Christians, Kurds, Palestinians	20.09
10	1	Nigeria	Ibo, Ijaw, Ogoni, Yoruba, Hausa (Muslims) and Christians in the North	18.41
11	2	Yemen	Zaydi Shi'a, 'Akhdam', Southerners	18.35
17	4	Central African Republic	Kaba (Sara), Mboum, Mbororo, Gula, Aka	15.88
23	13	Libya	Black Libyans, Sub-Saharan migrants, Tebu, Berbers	13.71
25	36	Mali	Tuareg, Arabs, Maure, and others in the north	13.11
26	5	Equatorial Guinea	Bubi, Annobon Islanders	12.99
27	19	Kenya	Borana, Kalenjin, Kikuyu, Luyha, Luo, Muslims, Turkana, Endorois, Masai, Ogiek, other indigenous groups	12.92
28	6	Algeria	Berbers, Saharawi	12.89

This is the eighth year that *Peoples under Threat* has used statistical analysis based on authoritative indicators to identify those communities or peoples around the world most at risk of mass killing. Unlike most early warning tools, *Peoples under Threat* was developed for the specific purpose of contributing to civilian protection. This year's release illustrates starkly, however, just how little we know about the efficacy of international action to prevent atrocity. It underlines the urgent need to track the consequences of any foreign military intervention, to ensure that intervention does not do more harm than good.

Rising threats in 2013

At least half the states that have risen most significantly in *Peoples under Threat* in 2013, and eight out of 10 of those most at risk, have been subject to recent large-scale or systematic foreign military interventions.

The two states that have risen most prominently in the index this year are both at the centre of intense controversy concerning international intervention. The recent general election in Pakistan saw fierce criticism of US military action, in particular the systematic use of unmanned drones to drop bombs in the north and west of the country. Drone killings, including an unverified number of civilian casualties, have caused intense resentment among communities in the tribal areas. While the elections were hailed as the first transfer of power from one elected government to another in Pakistan's history, they were marked by violence and the outcome shows deep regional divisions. Lashkar-e-Jhangvi and other sectarian extremists, widely believed to be funded from abroad, have intensified a murderous campaign against the Shi'a and other religious minorities, and have operated with almost complete impunity.

At least 93,000 people are now estimated by the UN to have been killed in Syria's conflict. This is the third year in a row that Syria has risen in the index, and previous fears expressed in *Peoples under Threat* that whole communities would become at risk of sectarian killings are sadly being increasingly realized. In June 2013 the US announced for the first time that it would provide direct military support to Syrian rebels, joining a

long list of other states that are already engaged in supporting one or other side in the war, including Qatar, Saudi Arabia, Turkey, Russia and Iran. The involvement of the Lebanese group Hezbollah in support of the Syrian government has also increased the danger of the conflict spilling further into Lebanon, which itself rose in the index this year.

In Yemen in 2012 a major military offensive, supported by the US, targeted Islamic militants in the south, and the conflict displaced tens of thousands of civilians. The US continued a separate campaign of drone strikes across the country. In the north, scene of an earlier Saudi Arabian military intervention in 2009, continuing conflict between al Houthi rebels and the government and Sunni tribes caused casualties and displacement in both Zaydi Shi'a and Sunni communities. Yemen now has the dubious distinction of having risen in the *Peoples under Threat* index seven years in a row.

The government of President François Bozizé of the Central African Republic had benefitted from military support from both neighbouring Chad and from France over the years, but he was finally overthrown in a rebellion in March 2013. Victorious fighters of the Séléka alliance have been responsible for a wave of human rights abuses, tens of thousands of people remained displaced and the humanitarian situation in the country has deteriorated markedly in one of the world's forgotten crises.

Libya and Mali are two recent cases where success has been claimed for large-scale foreign military interventions, the first in support of rebels, the second in support of the government. Both countries have risen sharply in the index this year, following major rises last year too.

NATO air power helped topple Libya's President Gaddafi in 2011 and led to democratic elections in 2012. Large areas of the country, however, remain under the effective control of different militia groups, and security for much of the population worsened over the last year. Most of the Sub-Saharan population were expelled during the rebellion in 2011 and dark-skinned Libyans, including former residents of Tawergha, remain vulnerable to racist attacks and arbitrary detention.

French President François Hollande was awarded the Houphouët-Boigny Peace Prize by

UNESCO in June 2013 for his decision to send French troops to Mali earlier in the year to regain the north of the country from Islamist rebels. Following the intervention, Arab properties in Timbuktu and other key northern towns were looted and much of the Arab population forced to flee, as were Tuaregs who were perceived to have initiated the rebellion. The UN estimated that some 470,000 people in all have fled the fighting, with Arabs and Tuaregs remaining at risk of reprisal attacks as well as inter-ethnic clashes in the north.

Peoples at greatest risk

At the head of the *Peoples under Threat* table are those country situations where peoples are at greatest risk. Somalia, Afghanistan and the Democratic Republic of Congo have all been subject to multiple military interventions by both foreign armies and inter-governmental organizations, over the course of decades.

Both the Kenyan and Ethiopian armies were active again in Somalia over the last year, conducting major bombing and ground operations against al Shabaab, a rebel group formed in 2006 to oppose a previous Ethiopian

invasion. The African Union mission in Somalia was able to claim considerable success in pushing al Shabaab back from major cities including Mogadishu, although the group was responsible for a deadly attack on the UN compound in June 2013 and continues to control large areas of South-Central Somalia, including those where the vulnerable Bantu population live. A further 78,000 people fled Somalia as refugees in 2012, according to UNHCR.

Civilian deaths in Afghanistan continue to run at nearly 3,000 a year, the great majority due to attacks by the Taliban and other anti-government forces. The US has sought peace talks with the Taliban in advance of a withdrawal of US troops from Afghanistan in 2014, but Tajik, Uzbek and Hazara leaders have formed a new National Front to oppose any accommodation with the Pashtun-dominated Taliban, in a move that underscores the deep ethnic divisions in the country.

Nigeria re-entered the top 10 this year as the threat rose from conflict between Christian and Muslim communities, much of it over land, in Plateau and neighbouring states and in the north-east. The Islamist group Boko Haram issued an ultimatum calling on Christians to leave in

Peoples most under threat – highest rated countries 2013

Rank	Country	Group	Total
1	Somalia	Minorities incl. Bantu, Benadiri and 'caste' groups (Gabooye etc.); clan members at risk in fighting incl. Hawiye, Darod, etc.	23.29
2	Sudan	Fur, Zaghawa, Massalit and others in Darfur; Dinka, Nuba, Beja	21.93
3	Afghanistan	Hazara, Pashtun, Tajiks, Uzbeks, Turkmen, Baluchis	21.44
4	Iraq	Shi'a, Sunnis, Kurds, Turkmen, Christians, Mandaeans, Yezidis, Shabak, Faili Kurds, Baha'is, Palestinians	20.59
5	Pakistan	Ahmadiyya, Baluchis, Hindus, Mohhajirs, Pashtun, Sindhis, other religious minorities	20.42
6	Syria	Political targets, Shi'a/Alawites, Assyrians, Kurds, Palestinians	20.09
7	Burma/Myanmar	Kachin, Karenni, Karen, Mons, Rakhine, Rohingyas, Shan, Chin (Zomis), Wa	20.06
8	Dem. Rep. of the Congo	Hema and Lendu, Hutu, Luba, Lunda, Tutsi/Banyamulenge, Batwa/Bambutu, other groups	19.92
9	Ethiopia	Anuak, Afars, Oromo, Somalis, smaller minorities	19.30
10	Nigeria	Ibo, Ijaw, Ogoni, Yoruba, Hausa (Muslims) and Christians in the North	18.41

January 2012 and then launched a campaign of attacks on Christians in the north-east, killing hundreds and displacing thousands. Following the imposition of a state of emergency in three states in north-eastern Nigeria in May 2013, accompanied by a media blackout, the Nigerian army has been accused of arbitrary killings and disappearances in its operations against Boko Haram.

In Darfur in Sudan the joint UN/African Union peace-keeping force (formerly the world's largest) scaled back to 16,000 troops as progress was made with the implementation of the Darfur peace agreement. Conflict between rebels and the government continued, however, and included attacks by the Sudanese air force and by government-backed militias on civilians in IDP camps. A set of humanitarian crises continue to unfold on both sides of the border with the newly-independent state of South Sudan. In South Kordofan and Blue Nile in Sudan, the Sudanese armed forces were responsible for indiscriminate shelling of villages in their campaign against the Sudan Revolutionary Front, an alliance of existing rebel groups. In the latest agreement between Sudan and South Sudan in March 2013, their respective forces were due to undertake a UN-monitored withdrawal from a demilitarized zone on the border, but violations have already been reported. Inter-ethnic violence continued in Jonglei state in South Sudan, particularly between Lou-Nuer and Murle.

International trade and cooperation

Foreign military intervention lies at one end of a spectrum of possible international engagement and it is instructive first to consider peaceful means of influencing a state's human rights performance.

Although international relations with any given state are complex and can have negative as well as positive effects on human rights, a condition of general isolation from international exchange and cooperation, when combined with other factors, signals danger. The *Peoples under Threat* index uses the country credit risk classification assigned by the Organization for Economic Cooperation and Development (OECD) as a proxy for low trade openness, one of the known antecedents to genocide or mass political killing (see box: 'How

is *Peoples under Threat* calculated?' on p. 219).

Under this rubric, embeddedness in the international system not only brings with it a range of economic benefits which it would be costly to lose, but also exposes a national government to a level of continuous pressure to conform to minimum international standards.

Globalization, the expansion of international trade and the growth in inter-governmental organizations have significantly reduced instances of international isolation. The remaining exceptions – of which North Korea is the most striking example – present profound human rights challenges.

Emerging from relative isolation over the last two years, Burma/Myanmar has made tentative moves towards democratization, most visibly in the appointment of a civilian government and the release from house arrest and election to Parliament of the opposition leader, Aung San Suu Kyi. Burma has accordingly fallen in the index this year, although it remains in the top 10. In addition to widespread human rights violations associated with renewed conflict in Kachin state, inter-community violence has caused the deaths of hundreds of Muslims, particularly Rohingya in Rakhine state. Dam construction and other major development projects across the country have drawn a huge increase in international investment, but have themselves created further concerns for indigenous and ethnic minority communities who fear displacement and the loss of their livelihoods.

Cooperation extends beyond trade relations. International cooperation to promote and encourage respect for human rights and fundamental freedoms is actually enshrined in international law as one of the founding principles of the UN. Such cooperation includes oversight mechanisms, including the UN Human Rights Council, through which member states' pledge to promote human rights can be scrutinized. Whether it be through the agencies of the UN, through regional inter-governmental organizations, or through bilateral cooperation, states can also benefit from a wide range of 'technical assistance' programmes, from advice on legal drafting and rights monitoring through to training in human rights standards for judges, lawyers and law enforcement agencies.

More generally, international aid for development is a major source of income for most of the world's poorest states, including many near the top of the *Peoples under Threat* table. Whether or not it is a formal condition for receiving aid, accepting international observation or assistance on human rights is often seen as part of the package. Conversely the removal of aid, or the threat of its removal, can provide a major lever of influence over a government to improve its human rights performance. In 2012, for example, the EU and a number of other governments partly suspended aid to Rwanda following a report by a UN group of experts into Rwandan support for the M23, a rebel group in neighbouring Democratic Republic of Congo (DRC) whose murderous activities have sparked a renewed humanitarian crisis.

The toolbox of coercion

Beyond international oversight and the provision or withholding of aid, a range of other means are available to the international community to seek to modify a state's behaviour. These include, but are not limited to, diplomatic pressure, litigation before international tribunals or the International Court of Justice, suspension or expulsion from international organizations, severance of diplomatic relations, economic sanctions, arms embargoes, international prosecutions of military or political leaders, and travel bans or asset freezes.

The use of a number of these tools is illustrated by the response to inter-ethnic violence in Kenya, when over 1,300 people were killed following a disputed general election in December 2007. Intense diplomatic pressure, including a threat from the EU Development Commissioner to reduce aid and the imposition of a US travel ban on a number of Kenyans, led to a set of power-sharing accords, mediated by former UN Secretary-General Kofi Annan. A commission of inquiry established under the accords recommended the prosecution of those most responsible for the violence, with a recourse to the International Criminal Court (ICC) should national prosecutions not progress. In the event, the ICC opened an investigation in 2010. A new general election in Kenya in March 2013 passed off relatively peacefully, but resulted in the election as President and Deputy President

of two men with outstanding ICC indictments for crimes against humanity for their role in the 2007–8 post-election violence. Kenya rose sharply again in the *Peoples under Threat* table this year.

Both Kofi Annan and his successor as UN Secretary-General, Ban Ki-moon, described the Kenya mediation as the first application of the new norm of 'responsibility to protect' (R2P). At the UN world summit in 2005, UN member states had agreed that, although an individual state carried the primary responsibility for protecting its population, the international community also had a 'responsibility to protect' populations from genocide, war crimes, ethnic cleansing and crimes against humanity. This responsibility was to be discharged through 'appropriate diplomatic, humanitarian and other peaceful means' but, should peaceful means be inadequate and national authorities manifestly fail to protect their populations, also through taking collective action, 'in a timely and decisive manner', through the UN Security Council.

Much of the groundwork for developing the norm of responsibility to protect was undertaken by the International Commission on Intervention and State Sovereignty, set up under the auspices of the Canadian government. Borrowing heavily from just war theory, the Commission identified six necessary criteria for a justified military intervention: just cause, right intention, last resort, proportional means, reasonable prospects and right authority. For the just cause threshold to be met, the Commission explained that there must be serious and irreparable harm – such as large-scale loss of life or ethnic cleansing – occurring to human beings or imminently likely to occur. The criteria of just cause and right intention in particular remain deeply controversial, given that most military interventions in history have not been undertaken for humanitarian reasons and that the intention or motivation of states can be difficult to certify.

The responsibility to protect envisages states taking collective or multi-lateral action, but it does not specify which form of mandate might be appropriate for such action, other than that it should be in accordance with the UN Charter, including Chapter VII. The first military implementation of the responsibility to protect is accepted to be Security Council Resolution

1973 in 2011, which authorized UN member states to 'take all necessary measures . . . to protect civilians and civilian populated areas' in Libya, including by the establishment of a no-fly zone (although NATO was later criticized for exceeding its mandate when it went on to support the overthrow of President Gaddafi). Since the 1990s, however, UN missions have evolved from a traditional peace-keeping role, in which lightly-armed personnel were deployed post-ceasefire with the consent of both parties to the conflict, to multi-function missions with wide humanitarian aims including, increasingly, 'peace enforcement'. The UN's largest peace-keeping operation, in the DRC, provides a good case study of this development, with the mission's latest incarnation including an 'intervention brigade' with the power to 'carry out targeted offensive operations' to neutralize armed groups threatening state authority and civilian security (UNSC 2098, March 2013).

Although military interventions authorized by the UN Security Council or other inter-governmental organizations have increased in recent years (see opposite), it should be noted that most interventions continue to be undertaken by neighbouring states or world powers. Furthermore, interventions using the regular forces of a national government or governments are themselves outnumbered by the widespread practice of providing military, financial or logistical support to proxy militias or rebel groups.

Armed intervention and mass killing: cause or effect?

Ten years ago in 2003 the United States led a military coalition to intervene in Iraq. One narrative for what then happened describes the removal of a government responsible for gross human rights abuses and the installation of a fledgling democracy. Another version of the same events tells how an illegal invasion started a war that has to date cost the lives of at least 112,000 civilians and left the country in a semi-permanent state of conflict, with approximately 400 civilians continuing to be killed every month.

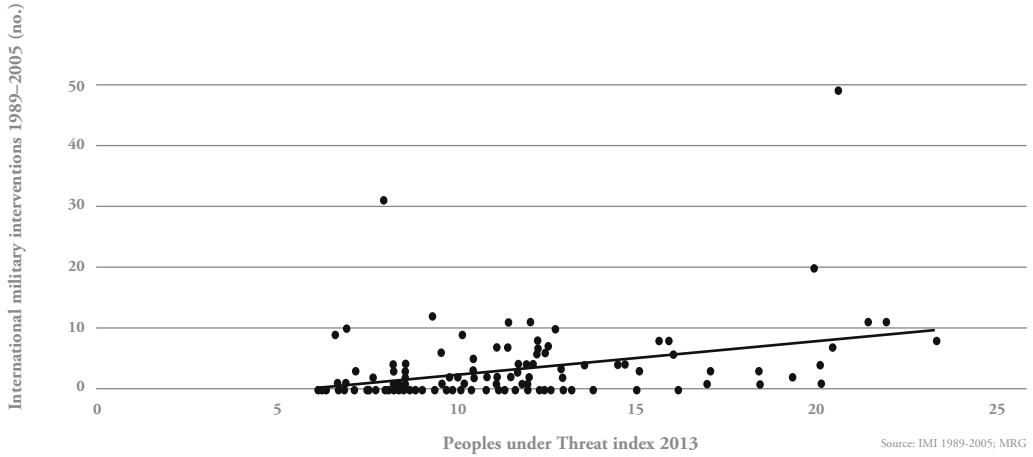
That both these narratives can exist, credibly, at the same time is an indication of the difficulty in identifying cause and effect in a series of events

that appear over-determined. The Iraqi case has perhaps occasioned more debate than any other in recent years, but difficult questions on the aims and effects of armed intervention could equally be posed concerning many of the critical country situations in the *Peoples under Threat* index, including *inter alia* Somalia, Afghanistan, Pakistan, the DRC, Yemen and Libya. In each case, humanitarian grounds have been among those cited to justify military intervention, but it remains hard to establish whether the majority of civilian killing is the *cause* or the *effect* of sustained intervention, particularly in the case of interventions that comprise multiple episodes.

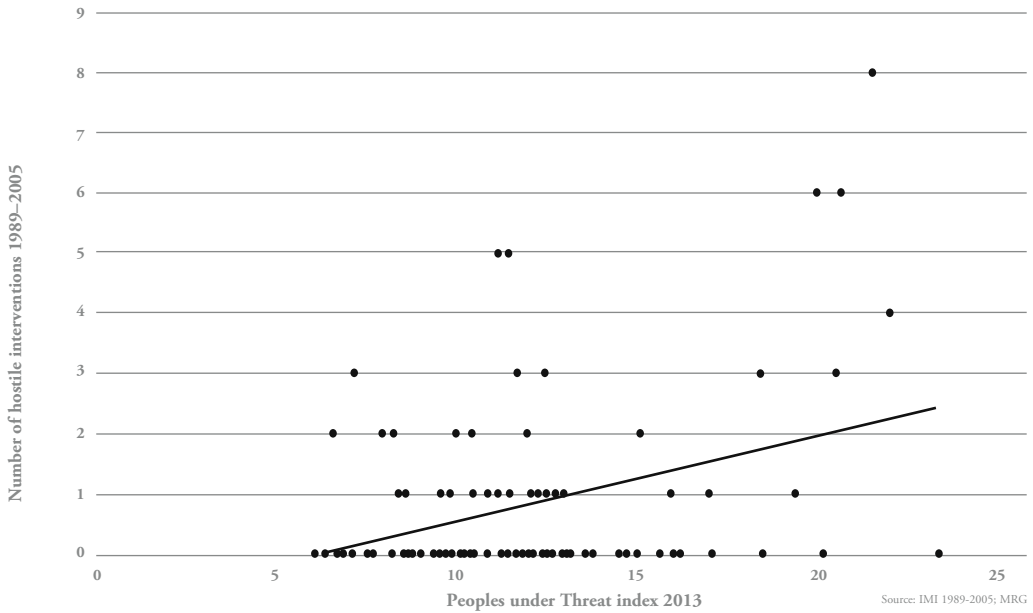
In specific cases it may be possible to draw at least interim conclusions. Even in the case of Iraq, most commentators would agree both that the population of Iraqi Kurdistan feel more secure following the removal of their nemesis Saddam Hussein and also that the 2003 invasion triggered an unprecedented level of sectarian violence between Arab Sunni and Shi'a. Two international military interventions that produced a definite, immediate improvement in civilian protection were the UK operations in Sierra Leone in 2000 to help halt a rebel advance on the capital Freetown; and the EU/French Operation Artemis to secure the town of Bunia in Ituri in the DRC in 2003. (It is notable that both these were limited operations focused on securing one urban area and were launched with the cooperation of the national host government.) However, with over 16 years' continuous experience of repeated foreign interventions by both foreign governments and inter-governmental actors, the DRC case more than any other demonstrates the complexity of disentangling the lines of causality linking intervention and civilian killing or protection.

A growing number of academic research institutes now compile data on inter-state conflict and other instances of international military action. Of particular interest is the updated International Military Intervention dataset (IMI), compiled by Jeffrey Pickering and Emizet F. Kisangani at Kansas State University. This records 444 separate instances of military intervention across international boundaries by regular armed forces from 1989 to 2005. It has the advantage of using the same definitions and

Peoples under threat following military interventions



Higher threat after hostile interventions



coding as an earlier dataset covering the Cold War era, thus providing a consistent body of data from 1946 onwards, and includes information on the direction of military intervention (for

example whether it was hostile, supportive or neutral) and on the motivation or issues driving intervention. (The data excludes support for proxy militias, paramilitaries, mercenaries or

other non-regular forces.)

IMI records an increase in the use of foreign military intervention, from approximately 16 foreign military interventions launched every year during the Cold War period to 26 interventions initiated per year in the post-Cold War years of 1990–2005. Interventions by major powers (i.e. the five permanent members of the UN Security Council) increased slightly, with US and French activities accounting for most of the increase, but the greatest proportional increase was seen in interventions mounted by international organizations, including the UN, NATO and other regional organizations (Pickering and Kisangani, 'The International Military Intervention Dataset: An updated resource for conflict scholars', *Journal of Peace Research* 46, 2009).

This finding of an increase in foreign military intervention is consistent with the high levels of armed intervention noted earlier in countries ranked highly in the 2013 *Peoples under Threat* index. Other studies in the literature demonstrate a relationship between armed intervention and an increase in human rights violations. Working from a sub-set of the IMI data for the period 1981–2001, Dursun Peksen finds that foreign military intervention increases the likelihood of violations of physical integrity rights, particularly in the case of interventions that are supportive towards the target government or neutral ('Does Foreign Military Intervention Help Human Rights?', *Political Research Quarterly* 65, 2012). He hypothesizes that the use of repression is essentially a policy choice adopted by the government and that supportive or neutral military intervention enhances the state's coercive power and encourages more repressive behaviour. Interestingly, he finds no major statistically significant difference between humanitarian intervention and non-humanitarian intervention. He notes the value of these findings in shedding light 'on the empirical relevance of ongoing policy debates showing that interventions might inadvertently do more harm than good – at least in the case of human rights – even if they are initiated by IGOs or liberal democracies'.

Peoples under Threat is designed to assess the risk to population groups not just from government repression but also from the activities

of rebel groups, from inter-ethnic or inter-religious conflict, or indeed from foreign attack. The correlation between the level of current threat to population groups and a history of international military intervention can be demonstrated by plotting the 2013 index (for 114 countries) against the IMI data on military interventions by target country over the period 1989–2005. The correlation is particularly strong for hostile interventions (i.e. those coded in IMI as opposing governments or supporting rebels). A higher number of *hostile* interventions in the 1989–2005 period corresponds to higher levels of current threat (see graph on p. 217).

Monitoring the impact of intervention

It should be stressed that even if there is a correlation between military intervention and a subsequent rise in the level of threat to civilian population groups, it cannot be assumed that one causes the other. There might be significant differences in the situation in target countries *ex ante*, or intervening variables – the nature or direction of the intervention, the level of wider international support – may be as or more important. But it does underline the need for more research. It also highlights the point that interventions, particularly belligerent ones, often do not turn out the way they were intended, as the case of Iraq tragically demonstrates.

One of the conditions for a justified intervention under the R2P doctrine is a reasonable prospect of success. It might be argued that a test based only on reasonableness sets the bar too low, but it would help if the test were correctly applied. Reasonable prospect is often judged just in terms of the immediate military objective, whether it be gaining air supremacy, defeating a military force, or establishing effective control of territory. But if the just cause for an armed intervention is civilian protection, then success should also be judged in terms of civilian protection. As Taylor Seybolt, author of a major study on military interventions, has argued: 'A *reasonable prospect of success* is as critical to legitimate humanitarian intervention as just cause. If an intervention is not likely to do more good than harm from a humanitarian point of view, it cannot be justified in humanitarian terms. This is true even if the other criteria of right authority, right intention, last resort and

proportional means are met. Despite its essential character, the prospect of success is undervalued and has been the subject of too little study. This lack of attention may help to explain why so many humanitarian interventions have gone awry' (Taylor B. Seybolt, *Humanitarian Military Intervention*, SIPRI, OUP, Oxford, 2007, p. 26).

There is perhaps no older ethical problem in politics than the morality of the use of force. The state will reserve to itself the monopoly of the legitimate means of violence, but when and how violence can be employed to maintain order are questions that have been posed by governments through the ages. In the era of decolonization, we also became familiar with the revolutionary's dilemma: is it right to spill blood to win liberty? Although the answer to such questions may be influenced by an estimation of how much blood might be necessary, it also depends on the wider political beliefs of the individual confronted by the dilemma and the relative value he or she places on life, as opposed to freedom or order. As such, the problem always escaped simple resolution.

In the current debates over responsibility to protect and armed intervention, the fundamental

moral question is perhaps more straightforward: how many lives should be risked to save other lives? The calculus is still complex, but the currency is the same. Perhaps the greatest scandal, under such circumstances, is the failure to monitor loss of life following an armed intervention, so the question can at least be put. After the Libyan intervention, for example, NATO was heavily criticised for failing to investigate over 70 civilian deaths caused by its aerial bombardment. But there remains even more confusion about the far greater numbers killed in the Libyan conflict by both government and rebel forces, the majority after the start of foreign intervention. Even today, credible estimates of the number killed range from 15,000 to 30,000 (around half of them civilians). If there is a basic failure even to count the dead, then the relative success of an intervention can never be properly evaluated.

As the threat of mass killing continues to be faced by peoples around the world, there is an urgent need for reliable data on the consequences as well as the causes of military intervention, to ensure that civilian protection is improved in practice. *Additional research by Jack Dentith.*

How is *Peoples under Threat* calculated?

Since the genocide in Rwanda in 1994, our ability to identify those situations most likely to lead to genocide or mass killing has improved. A number of comparative studies of the factors preceding historic episodes of political mass killing had been undertaken since the 1970s, including by Helen Fein and Ted Robert Gurr, but it was not until the 1990s that researchers such as Rudolf Rummel and Matthew Krain pioneered quantitative longitudinal analysis of a wide range of such factors, enabling the testing of different causal hypotheses. Rummel, for example, showed the very strong relationship between concentration of government power and state mass murder; Krain demonstrated the correlation between existing armed conflict or political instability and the onset and severity of mass killing.

Following the early work of the Clinton administration's policy initiative on geno-

cide early warning and prevention, Professor Barbara Harff, a senior consultant with the US State Failure Task Force, constructed and tested models of the antecedents of genocide and political mass murder and her results were published in 2003 ('Assessing Risks of Genocide and Political Mass Murder since 1955', *American Political Science Review* 97, February 2003). Her optimal model identifies six preconditions that make it possible to distinguish, with 74 per cent accuracy, between internal wars and regime collapses in the period 1955–1997 that did, and those that did not, lead to genocide and political mass murder (politicide). The six preconditions are: political upheaval; previous genocides or politicides; exclusionary ideology of the ruling elite; autocratic nature of the regime; minority character of the ruling elite; and low trade openness.

Minority Rights Group International has drawn on these research findings to construct the *Peoples under Threat* table, although

responsibility for the final table is exclusively our own. *Peoples under Threat* is specifically designed to identify the risk of genocide, mass killing or other systematic violent repression, unlike most other early warning tools, which focus on violent conflict as such. Its primary application is civilian protection.

Indicators of conflict are included in the table's construction, however, as most, although not all, episodes of mass ethnic or religious killing occur during armed conflicts. War provides the state of emergency, domestic mobilization and justification, international cover, and in some cases the military and logistic capacity, that enable massacres to be carried out. Some massacres, however, occur in peacetime, or may accompany armed conflict from its inception, presenting a problem to risk models that focus exclusively on current conflicts. In addition, severe and even violent repression of minorities may occur for years before the onset of armed conflict provides the catalyst for larger scale killing.

The statistical indicators used all relate to the state. The state is the basic unit of enquiry, rather than particular ethnic or religious groups at risk, as governments or militias connected to the government are responsible for most cases of genocidal violence. Formally, the state will reserve to itself the monopoly over the means of violence, so that where non-state actors are responsible for widespread or continued killing, it usually occurs with either the complicity of the state or in a 'failed state' situation where the rule of law has disintegrated. Certain characteristics at the level of the state will greatly increase the likelihood of atrocity, including habituation to illegal violence among the armed forces or police, prevailing impunity for human rights violations, official tolerance or encouragement of hate speech against particular groups, and in extreme cases, prior experience of mass killing. Egregious episodes of mass killing targeted principally at one group have also seen other groups deliberately decimated or destroyed.

However, some groups may experience higher levels of discrimination and be at greater

risk than others in any given state. Minority Rights Group International has identified those groups in each state which we believe to be under most threat. (This does not mean that other groups or indeed the general population may not also be at some risk.) It should be noted that although these groups are most often minorities, in some cases ethnic or religious majorities will also be at risk and in relevant cases are therefore also listed in the table. In some cases, all the groups in the country are at risk of ethnic or sectarian killing.

One indicator that has been tested and discarded by a number of studies is the general level of ethnic or cultural diversity in a society. Krain did not find any correlation between 'ethnic fractionalization' and the onset of genocide or political mass killing. Similarly, neither of the patterns of ethnic diversity tested by Harff had any effect on the likelihood of mass killing (although she did find the minority character of the ruling elite to be significant). These findings are supported by research on the relationship between diversity and conflict.

The overall measure is based on a basket of 10 indicators. These include indicators of democracy or good governance from the World Bank; conflict indicators from the Center for Systemic Peace and other leading global conflict research institutes; indicators of group division or elite factionalization from the Fund for Peace and the Carnegie Endowment for International Peace; the State Failure Task Force data on prior genocides and politicides; and the country credit risk classification published by the OECD (as a proxy for trade openness). For citations and further information, see the notes to the table. For a fuller discussion of the methodology, see *State of the World's Minorities 2006*.

Based on current indicators from authoritative sources, *Peoples under Threat* seeks to identify those groups or peoples most under threat in 2013. ■

Country	Group	Conflict indicators		
		A. Self-determination conflicts	B. Major armed conflict	C. Prior genocide/politicide
Somalia	Minorities incl. Bantu, Benadiri and 'caste' groups (Gabooye etc.); clan members at risk in fighting incl. Hawiye, Darod, etc.	4	2	1
Sudan	Fur, Zaghawa, Massalit and others in Darfur; Ngok Dinka, Nuba, Beja	5	2	1
Afghanistan	Hazara, Pashtun, Tajiks, Uzbeks, Turkmen, Baluchis	4	2	1
Iraq	Shi'a, Sunnis, Kurds, Turkmen, Christians, Mandaeans, Yezidis, Shabak, Faili Kurds, Bahá'ís, Palestinians	5	2	1
Pakistan	Shi'a (incl. Hazara), Ahmadiyya, Hindus and other religious minorities; Baluchis, Mohhajirs, Pashtun, Sindhis	5	2	1
Syria	Political targets, Shi'a/Alawites, Christians, Kurds, Palestinians	5	2	1
Burma/Myanmar	Kachin, Karenni, Karen, Mons, Rakhine, Rohingyas, Shan, Chin (Zomis), Wa	5	2	1
Dem. Rep. of the Congo	Hema and Lendu, Hutu, Luba, Lunda, Tutsi/Banyamulenge, Batwa/Bambutu, other groups	2	2	1
Ethiopia	Anuak, Afars, Oromo, Somalis, smaller minorities	5	2	1
Nigeria	Ibo, Ijaw, Ogoni, Yoruba, Hausa (Muslims) and Christians in the North	5	2	1
Yemen	Zaydi Shi'a, 'Akhdam', Southerners	4	2	0
Iran	Arabs, Azeris, Bahá'ís, Baluchis, Kurds, Turkomen	5	0	1
Israel/OPT	Palestinians in Gaza/West Bank, Israeli Palestinians, Bedouin	5	2	0
South Sudan	Murle, Nuer, Dinka, Anuak, Jie, Kachipo	0	2	0
Zimbabwe	Ndebele, Europeans, political/social targets	2	0	1
Chad	'Black African' groups, Arabs, Southerners	3	1	0
Central African Republic	Kaba (Sara), Mboum, Mbororo, Gula, Aka	0	2	0
Cote d'Ivoire	Northern Mande (Dioula), Senoufo, Bete, newly-settled groups	3	1	0
Philippines	Indigenous peoples, Moros (Muslims), Chinese	5	2	1
Russian Federation	Chechens, Ingush and others in North Caucasus; indigenous northern peoples, Roma, Jews	5	2	1
Sri Lanka	Tamils, Muslims	4	1	1
Burundi	Hutu, Tutsi, Batwa	0	0	1
Libya	Black Libyans, Sub-Saharan migrants, Tebu, Berbers	2	1	0

Indicators of group division			Democracy/governance indicators				Total
D. Massive movement – refugees and IDPs	E. Legacy of vengeance – group grievance	F. Rise of factionalized elites	G. Voice and accountability	H. Political stability	I. Rule of law	J. OECD country risk classification	
10.0	9.6	9.8	-2.088	-3.073	-2.354	7	23.29
9.9	10.0	9.9	-1.714	-2.609	-1.259	7	21.93
9.0	9.4	9.4	-1.489	-2.513	-1.937	7	21.45
8.5	9.7	9.6	-1.130	-1.955	-1.500	7	20.59
9.0	9.6	9.1	-0.830	-2.697	-0.899	7	20.42
9.0	9.2	8.7	-1.738	-1.839	-0.659	7	20.09
8.2	8.7	8.6	-1.857	-1.159	-1.423	7	20.06
9.7	9.3	9.5	-1.484	-2.210	-1.599	7	19.92
8.7	8.1	8.7	-1.335	-1.633	-0.714	7	19.30
6.5	9.7	9.8	-0.757	-1.940	-1.248	5	18.41
8.7	9.0	9.8	-1.351	-2.291	-1.250	7	18.35
7.6	8.6	9.3	-1.549	-1.455	-0.902	7	17.03
7.3	9.5	8.1	-0.976	-1.977	-0.434	7	16.91
9.9	10.0	10.0	-1.066	-1.134	-1.481	8	16.17
8.4	8.7	9.8	-1.457	-1.042	-1.755	7	16.12
9.5	9.1	9.8	-1.350	-1.291	-1.462	7	15.96
9.7	8.5	9.1	-1.123	-2.036	-1.283	7	15.88
9.0	9.0	9.9	-1.129	-1.414	-1.262	7	15.58
6.2	7.6	8.0	-0.015	-1.386	-0.512	4	15.05
5.0	7.9	8.0	-0.942	-0.875	-0.780	3	14.95
8.7	9.1	9.2	-0.535	-0.542	-0.075	6	14.65
8.9	8.0	7.9	-0.979	-1.812	-1.154	7	14.46
5.1	7.0	8.0	-1.573	-1.010	-1.159	7	13.71

Country	Group	Conflict indicators		
		A. Self-determination conflicts	B. Major armed conflict	C. Prior genocide/politicide
Lebanon	Druze, Maronite Christians, Palestinians, Shi'a, Sunnis	2	1	0
Mali	Tuareg, Arabs, Maure, and others in the north	5	2	0
Equatorial Guinea	Bubi, Annobon Islanders	1	0	1
Kenya	Borana, Kalenjin, Kikuyu, Luyha, Luo, Muslims, Turkana, Endorois, Masai, Ogiek, other indigenous groups	2	1	0
Algeria	Berbers, Saharawi	2	1	1
Kyrgyzstan	Uzbeks, Russians	1	1	0
Bosnia and Herzegovina	Croats, Bosniac Muslims, Serbs, Roma	2	0	1
Nepal	Madheshis (Terai), Dalits, Janajati, linguistic minorities	2	0	0
Thailand	Chinese, Malay-Muslims, Northern Hill Tribes	5	2	0
Uganda	Acholi, Karamojong, Basongora, Batwa	1	0	1
Guinea	Fulani (Peul), Malinke	0	0	0
Laos	Hmong, other highland peoples	4	0	0
Turkey	Kurds, Alevis, Roma, Armenians and other Christians	5	2	0
Angola	Bakongo, Cabindans, Ovimbundu, Pastoralists, San and Kwisi	2	0	1
Eritrea	Afars, Saho, Tigre, religious minorities	0	0	0
Georgia	Adzhars, Abkhazians, South Ossetians	4	1	0
Colombia	Political/social targets, Afro-descendants, indigenous peoples	3	2	0
Kosovo	Serbs, Roma/Ashkali/Egyptians, Bosniaks, Turks, Gorani	4	0	0
Rwanda	Hutu, Tutsi, Batwa	0	0	1
China	Tibetans, Uyghurs, Mongols, Hui, religious minorities	5	0	1
Uzbekistan	Tajiks, Islamic political groups, religious minorities, Karakalpaks, Russians	1	0	0
Niger	Djerema-songhai, Hausa, Tuaregs	4	0	0
Tajikistan	Uzbeks, Pamiris, Russians	1	0	0
Bangladesh	Ahmadiyya, Hindus, other religious minorities; Chittagong Hill Tribes	3	0	0
Djibouti	Afars	3	0	0
Cambodia	Cham, Vietnamese, indigenous hill tribes (Khmer Leou)	0	0	1
Azerbaijan	Armenians	4	0	0
North Korea	Political/social targets, religious minorities	0	0	0

Indicators of group division			Democracy/governance indicators				Total
D. Massive movement – refugees and IDPs	E. Legacy of vengeance – group grievance	F. Rise of factionalized elites	G. Voice and accountability	H. Political stability	I. Rule of law	J. OECD country risk classification	
8.2	8.4	9.1	-0.405	-1.546	-0.676	7	13.54
5.5	6.0	4.5	0.139	-0.710	-0.503	7	13.11
3.0	6.6	8.2	-1.853	-0.092	-1.207	7	12.99
8.4	8.9	9.0	-0.226	-1.307	-1.010	6	12.92
6.5	8.1	6.8	-1.027	-1.352	-0.822	3	12.89
5.3	8.4	8.3	-0.754	-1.047	-1.250	7	12.85
6.5	8.0	8.7	-0.209	-0.903	-0.336	7	12.69
7.7	9.0	8.2	-0.526	-1.550	-0.987	7	12.59
6.7	7.8	8.8	-0.448	-1.020	-0.241	3	12.47
8.2	7.7	8.7	-0.544	-1.098	-0.398	6	12.40
8.0	7.9	9.2	-0.928	-1.428	-1.474	7	12.39
5.5	6.3	8.6	-1.603	0.009	-0.918	7	12.29
6.5	8.6	7.5	-0.168	-0.927	0.077	4	12.28
6.9	6.5	7.0	-1.167	-0.332	-1.230	5	12.25
7.1	6.4	8.1	-2.158	-0.790	-1.274	7	12.20
7.2	8.3	9.1	-0.180	-0.750	-0.163	6	12.19
8.4	7.2	7.7	-0.148	-1.254	-0.264	4	12.04
6.3	7.9	8.0	-0.258	-1.128	-0.574	7	12.03
7.6	8.5	7.9	-1.287	-0.047	-0.306	7	12.01
5.9	7.9	6.9	-1.644	-0.698	-0.428	2	11.97
5.7	7.7	8.7	-2.026	-0.607	-1.392	6	11.96
6.9	7.7	8.6	-0.296	-0.882	-0.495	7	11.91
5.6	6.9	8.3	-1.352	-1.006	-1.208	7	11.91
6.8	8.9	8.9	-0.312	-1.498	-0.719	6	11.88
6.9	6.5	7.5	-1.328	0.270	-0.746	8	11.78
5.9	7.3	8.0	-0.905	-0.440	-1.029	6	11.65
7.6	7.2	7.8	-1.307	-0.566	-0.871	5	11.64
5.3	6.6	7.7	-2.187	-0.446	-1.302	7	11.58

Country	Group	Conflict indicators		
		A. Self-determination conflicts	B. Major armed conflict	C. Prior genocide/politicide
Cameroon	'Westerners', Southerners	2	0	0
Haiti	Political/social targets	0	0	0
Indonesia	Acehnese, Chinese, Dayaks, Madurese, Papuans, religious minorities	5	0	1
Venezuela	Indigenous peoples, Afro-descendants	0	0	0
Egypt	Copts, Shi'a, Bahá'ís; Nubians, Bedouin	0	1	0
India	Assamese, Bodos, Nagas, Tripuras, other Adivasis; Kashmiris, Sikhs, Muslims, Dalits	5	2	0
Guinea Bissau	Balanta, Fula (Fulani), Manjaco, Mandinga, Papel, Ejamat (Felupe), Jola (Diola), Susu, Cape Verdeans	0	0	0
Mauritania	Haratins ('Black Moors'), Kewri	0	0	0
Ecuador	Afro-descendants, indigenous peoples	2	0	0
Serbia	Bosniaks, Ethnic Albanians, Croats, Roma	2	0	1
Vietnam	Montagnards (Degar), other highland peoples, religious minorities	2	0	1
Nicaragua	Indigenous peoples, Creoles	3	0	0
Timor Leste	'Westerners', 'Easterners', Muslims, Chinese	0	0	0
Guatemala	Indigenous peoples, Garifuna	0	0	1
Belarus	Poles	0	0	0
Congo (Rep.)	Lari, M'Boshi, Aka	1	0	0
Liberia	Dan, Krahn, Ma, other groups	0	0	0
Turkmenistan	Uzbeks, Russians, Kazakhs, religious minorities	0	0	0
Fiji	East Indians, Fijians	0	0	0

Notes to Table

Sources of the indicators are as follows:

- Conflict indicators:* The base data used was Monty G Marshall, 'Major Episodes of Political Violence 1946–2012' (Center for Systemic Peace, 2013) and, for self-determination conflicts, Monty G Marshall and Ted R Gurr, 'Peace and Conflict 2005' (CIDCM, University of Maryland, 2005) updated for 2012 using figures from Center for Systemic Peace, MRG and the Heidelberg Institute for International Conflict Research (Conflict Barometer 2012, Heidelberg, HIIK, 2013).
- Self-determination conflicts in 2013 were ranked on a scale of 0–5 as follows: 5 = ongoing armed conflict; 4 = contained armed conflict; 3 = settled armed conflict; 2 = militant politics; 1 = conventional politics. Major armed conflicts were classified as 2 = ongoing in late 2012; 1 = emerging from conflict since 2007 or ongoing conflict with deaths under 1,000.
- Prior genocide or politicide:* Harff, US Political Instability Task Force (formerly State Failure Task Force). 1 = one or more episodes since 1945.
- Indicators of Group Division:* Failed States Index,

Indicators of group division			Democracy/governance indicators				Total
D. Massive movement – refugees and IDPs	E. Legacy of vengeance – group grievance	F. Rise of factionalized elites	G. Voice and accountability	H. Political stability	I. Rule of law	J. OECD country risk classification	
7.0	7.5	9.2	-1.064	-0.613	-1.038	6	11.41
8.1	7.0	9.0	-0.728	-0.905	-1.376	7	11.40
6.3	7.1	7.0	-0.082	-0.820	-0.662	3	11.33
4.5	6.7	7.3	-0.924	-1.301	-1.630	7	11.32
6.4	8.8	8.8	-1.127	-1.286	-0.419	5	11.21
5.5	7.9	6.8	0.405	-1.201	-0.081	3	11.12
7.5	5.7	9.2	-0.968	-0.702	-1.311	7	11.09
6.5	7.5	8.1	-0.954	-1.187	-0.887	7	11.09
6.0	6.9	8.2	-0.309	-0.728	-1.140	7	11.07
6.3	7.9	8.0	0.291	-0.334	-0.330	6	10.82
4.4	6.0	6.9	-1.483	0.169	-0.465	5	10.79
4.3	6.2	6.8	-0.577	-0.381	-0.710	7	10.43
7.7	6.8	8.3	0.096	-0.504	-1.188	8	10.40
5.9	7.1	6.0	-0.347	-0.726	-1.030	5	10.39
3.3	6.5	8.0	-1.630	-0.287	-1.076	7	10.34
7.7	6.3	6.7	-1.053	-0.240	-1.159	6	10.16
8.9	6.5	8.4	-0.298	-0.495	-0.961	7	10.10
3.9	6.4	7.7	-2.115	0.214	-1.412	6	10.06
3.3	7.6	7.9	-0.987	0.021	-0.905	8	10.01

Fund for Peace and the Carnegie Endowment for International Peace, 2012.

- *Democracy/Governance Indicators*: Annual Governance Indicators, World Bank, 2012.
- *OECD country risk classification*: Organisation for Economic Cooperation and Development, 'Country Risk Classifications of the Participants to the Arrangement on Officially Supported Export Credits', January 2013. Where no classification is given, a value of 8 was accorded.

Data for Kosovo include some indicators relating to Serbia. Where separate indicators are available for

Israel and the Occupied Palestinian Territories, the latter have been used.

Indicators were rebased as necessary to give an equal weighting to the five categories above, with the exception of the prior geno-/politicide indicator. As a dichotomous variable this received a lesser weighting to avoid too great a distortion to the final ranking. Resulting values were then summed.

The full formula is:

$$(A/2) + (B \times 1.25) + (C \times 2) + (D+E+F)/6 + (G+H+I)/-1 + (J \times 0.625)$$

Status of ratification of major international and regional instruments relevant to minority and indigenous rights

as of 1 February 2012

■ Ratification, accession or succession.

□ Signature not yet followed by ratification.

■► Ratification of ICERD and Declaration on Article 14.

■► Ratification of ICERD and Signature of Declaration on Article 14.

■● Ratification of ICCPR and Optional Protocol.

■○ Ratification of ICCPR and Signature of Optional Protocol.

□○ Signature of ICCPR and Optional Protocol.

	International Convention on the Prevention and Punishment of the Crime of Genocide 1948	International Convention on the Elimination of All Forms of Racial Discrimination 1965	International Covenant on Civil and Political Rights 1966	International Covenant on Economic, Social and Cultural Rights 1966
Africa				
Algeria	■	■►	■●	■
Angola			■●	■
Benin		■	■●	■
Botswana		■	■	
Burkina Faso	■	■	■●	■
Burundi	■	■	■	■
Cameroon		■	■●	■
Cape Verde		■	■●	■
Central African Republic		■	■●	■
Chad		■	■●	■
Comoros	■	■	□	□
Congo		■	■●	■
Côte d'Ivoire	■	■	■●	■
Democratic Republic of the Congo	■	■	■●	■
Djibouti		■	■●	■
Egypt	■	■	■	■
Equatorial Guinea		■	■●	■
Eritrea		■	■	■
Ethiopia	■	■	■	■
Gabon	■	■	■	■
Gambia	■	■	■●	■
Ghana	■	■	■●	■
Guinea	■	■	■●	■
Guinea Bissau		■	■○	■
Kenya		■	■	■
Lesotho	■	■	■●	■
Liberia	■	■	■○	■
Libyan Arab Jamahiriya	■	■	■●	■
Madagascar		■	■●	■
Malawi		■	■●	■
Mali	■	■	■●	■
Mauritania		■	■	■
Mauritius		■	■●	■
Morocco	■	■►	■	■
Mozambique	■	■	■	
Namibia	■	■	■●	■
Niger		■	■●	■

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	International Convention on the Prevention and Punishment of the Crime of Genocide 1948	International Convention on the Elimination of All Forms of Racial Discrimination 1965	International Covenant on Civil and Political Rights 1966	International Covenant on Economic, Social and Cultural Rights 1966
Nigeria	■	■	■	■
Rwanda	■	■	■	■
Sahrawi Arab Democratic Republic				
São Tomé and Príncipe		□	□○	□
Senegal	■	■►	■●	■
Seychelles	■	■	■●	■
Sierra Leone		■	■	■
Somalia		■	■●	■
South Africa	■	■►	■●	□
Sudan	■	■	■	■
Swaziland		■	■	■
Togo	■	■	■●	■
Tunisia	■	■	■●	■
Uganda	■	■	■●	■
United Republic of Tanzania	■	■	■	■
Zambia		■	■●	■
Zimbabwe	■	■	■	■
Americas				
Antigua and Barbuda	■	■		
Argentina	■	■►	■●	■
Bahamas	■	■	■	■
Barbados	■	■	■●	■
Belize	■	■	■	□
Bolivia	■	■►	■●	■
Brazil	■	■►	■●	■
Canada	■	■	■●	■
Chile	■	■►	■●	■
Colombia	■	■	■●	■
Costa Rica	■	■►	■●	■
Cuba	■	■	□	□
Dominica			■	■

Convention on the Elimination of All Forms of Discrimination against Women 1979	Convention on the Rights of the Child 1989	ILO 111 Discrimination (Employment and Occupation) Convention 1958	ILO 169 Convention Concerning Indigenous and Tribal Peoples in Independent Countries 1989	International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families 1990	ICC Rome Statute of the International Criminal Court 1998	African Charter on Human and Peoples' Rights 2003	African Charter on the Rights and Welfare of the Child 1990
■	■	■		■	■	■	■
■	■	■		■		■	■
						■	□
■	■	■		□	□	■	□
■	■	■		■	■	■	■
■	■	■		■	■	■	■
■	■	■		□	■	■	■
	□	■				■	□
■	■	■			■	■	■
	■	■			□	■	■
■	■	■				■	□
■	■	■		□		■	■
■	■	■			■	■	□
■	■	■		■	■	■	■
■	■	■			■	■	■
■	■	■			■	■	■
■	■	■			□	■	■
						American Convention on Human Rights 1969	Additional Protocol to the American Convention on Human Rights in the area of Economic, Social and Cultural Rights 1988
■	■	■			■		
■	■	■	■	■	■	■	■
■	■	■			□		
■	■	■			■	■	
■	■	■	■	■	■	■	■
■	■	■	■	■	■	■	■
■	■	■	■	■	■	■	■
■	■	■	■	■	■	■	■
■	■	■	■	■	■	■	□
■	■	■	■	■	■	■	■
■	■	■	■	■	■	■	■
■	■	■	■	■	■	■	■
■	■	■	■	■	■	■	■

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	International Convention on the Prevention and Punishment of the Crime of Genocide 1948	International Convention on the Elimination of All Forms of Racial Discrimination 1965	International Covenant on Civil and Political Rights 1966	International Covenant on Economic, Social and Cultural Rights 1966
Dominican Republic	□	■	■●	■
Ecuador	■	■▶	■●	■
El Salvador	■	■	■●	■
Grenada		□	■	■
Guatemala	■	■	■●	■
Guyana		■	■●	■
Haiti	■	■	■	
Honduras	■	■	■●	■
Jamaica	■	■	■●	■
Mexico	■	■▶	■●	■
Nicaragua	■	■	■●	■
Panama	■	■	■●	■
Paraguay	■	■	■●	■
Peru	■	■▶	■●	■
Saint Kitts and Nevis		■		
Saint Lucia		■		
Saint Vincent and the Grenadines	■	■	■●	■
Suriname		■	■●	■
Trinidad and Tobago	■	■	■●	■
United States of America	■	■	■	□
Uruguay	■	■▶	■●	■
Venezuela	■	■▶	■●	■
Asia				
Afghanistan	■	■	■	■
Bangladesh	■	■	■	■
Bhutan		□		
Brunei Darussalam				
Cambodia	■	■	■○	■
China	■	■	□	■
Democratic People's Republic of Korea	■		■	■
India	■	■	■	■
Indonesia		■	■	■
Japan		■	■	■
Kazakhstan	■	■▶	■●	■
Kyrgyzstan	■	■	■●	■
Lao People's Democratic Republic	■	■	■	■

Status of ratification of major international and regional instruments relevant to minority and indigenous rights

as of 1 February 2012

- Ratification, accession or succession.
- Signature not yet followed by ratification.

■► Ratification of ICERD and Declaration on Article 14.

■► Ratification of ICERD and Signature of Declaration on Article 14.

■● Ratification of ICCPR and Optional Protocol.

■○ Ratification of ICCPR and Signature of Optional Protocol.

□○ Signature of ICCPR and Optional Protocol.

	International Convention on the Prevention and Punishment of the Crime of Genocide 1948	International Convention on the Elimination of All Forms of Racial Discrimination 1965	International Covenant on Civil and Political Rights 1966	International Covenant on Economic, Social and Cultural Rights 1966
Malaysia	■			
Maldives	■	■	■●	■
Mongolia	■	■	■●	■
Myanmar	■			
Nepal	■	■	■●	■
Pakistan	■	■	■	■
Philippines	■	■	■●	■
Republic of Korea	■	■►	■●	■
Singapore	■			
Sri Lanka	■	■	■●	■
Tajikistan		■	■●	■
Thailand		■	■	■
Timor Leste		■	■	■
Turkmenistan		■	■●	■
Uzbekistan	■	■	■●	■
Vietnam	■	■	■	■
Europe				
Albania	■	■	■●	■
Andorra	■	■►	■●	
Armenia	■	■	■●	■
Austria	■	■►	■●	■
Azerbaijan	■	■►	■●	■
Belarus	■	■	■●	■
Belgium	■	■►	■●	■
Bosnia and Herzegovina	■	■	■●	■
Bulgaria	■	■►	■●	■
Croatia	■	■	■●	■
Cyprus	■	■►	■●	■
Czech Republic	■	■►	■●	■
Denmark	■	■►	■●	■
Estonia	■	■►	■●	■
Finland	■	■►	■●	■
France	■	■►	■●	■
Georgia	■	■►	■●	■

Convention on the Elimination of All Forms of Discrimination against Women 1979	Convention on the Rights of the Child 1989	ILO 111 Discrimination (Employment and Occupation) Convention 1958	ILO 169 Convention Concerning Indigenous and Tribal Peoples in Independent Countries 1989	International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families 1990	ICC Rome Statute of the International Criminal Court 1998		
■	■						
■	■				■		
■	■	■			■		
■	■						
■	■	■	■				
■	■	■					
■	■	■		■	■		
■	■	■			■		
■	■	■					
■	■	■		■	■		
■	■				□		
■	■			■	■		
■	■	■					
■	■	■			□		
■	■	■					
						European Charter for Regional or Minority Languages 1992	Framework Convention for the Protection of National Minorities 1995
■	■	■		■	■		■
■	■				■		
■	■	■			□	■	■
■	■	■			■	■	■
■	■	■		■		□	■
■	■	■			■		⊕
■	■	■		■	■	■	■
■	■	■			■		■
■	■	■			■	■	■
■	■	■			■	■	■
■	■	■			■	■	■
■	■	■	■		■	■	■
■	■	■			■		■
■	■	■			■	■	■
■	■	■			■	□	
■	■	■			■		■

Status of ratification of major international and regional instruments relevant to minority and indigenous rights

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Germany	■	■▶	■●	■
Greece	■	■	■●	■
Holy See		■		
Hungary	■	■▶	■●	■
Iceland	■	■▶	■●	■
Ireland	■	■▶	■●	■
Italy	■	■▶	■●	■
Latvia	■	■	■●	■
Liechtenstein	■	■▶	■	■
Lithuania	■	■	■●	■
Luxembourg	■	■▶	■●	■
Malta		■▶	■●	■
Monaco	■	■▶	■	■
Montenegro	■	■	■●	■
Netherlands	■	■▶	■●	■
Norway	■	■▶	■●	■
Poland	■	■▶	■●	■
Portugal	■	■▶	■●	■
Republic of Moldova	■	■	■●	■
Romania	■	■▶	■●	■
Russian Federation	■	■▶	■●	■
San Marino		■	■●	■
Serbia	■	■	■●	■
Slovakia	■	■	■●	■
Slovenia	■	■	■●	■
Spain	■	■▶	■●	■
Sweden	■	■▶	■●	■
Switzerland	■	■▶	■	■
The former Yugoslav Republic of Macedonia	■	■	■●	■
Turkey	■	■	■○	■
Ukraine	■	■▶	■●	■
United Kingdom of Great Britain and Northern Ireland	■	■	■	■
Middle East				
Bahrain	■	■	■	■
Iran (Islamic Republic of)	■	■	■	■

Status of ratification of major international and regional instruments relevant to minority and indigenous rights

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Iraq	■	■	■	■
Israel	■	■	■	■
Jordan	■	■	■	■
Kuwait	■	■	■	■
Lebanon	■	■	■	■
Oman		■		
Qatar		■		
Saudi Arabia	■	■		
Syrian Arab Republic	■	■	■	■
United Arab Emirates	■	■		
Yemen	■	■	■	■
Oceania				
Australia	■	■▶	■●	■
Cook Islands				
Fiji	■	■		
Kiribati				
Marshall Islands				
Micronesia (Federated States of)				
Nauru		□	□○	
New Zealand	■	■	■●	■
Niue				
Palau		□	□	
Papua New Guinea	■	■	■	■
Samoa			■	
Solomon Islands		■		■
Tonga	■	■		
Tuvalu				
Vanuatu			■	
Number of states parties	141 (1 sig)	175 (45 Art 14)	167 (115 op)	160 (6 sig)

Compiled by *Natascha Horsfield and Electra Barbouri*

Sources:

<http://treaties.un.org/Pages/Treaties.aspx?id=4&subid=A&lang=en>
 (http://www2.ohchr.org/english/bodies/docs/RatificationStatus.pdf this has been fully updated as of 2006 so above link more relevant)
<http://www.unhcr.ch/tbs/doc.nsf/Statusfset?OpenFrameSet>
<http://www.iccnw.org/?mod=romesignatures>

Who are minorities?

Minorities of concern to MRG are disadvantaged ethnic, national, religious, linguistic or cultural groups who are smaller in number than the rest of the population and who may wish to maintain and develop their identity. MRG also works with indigenous peoples.

Other groups who may suffer discrimination are of concern to MRG, which condemns discrimination on any ground. However, the specific mission of MRG is to secure the rights of minorities and indigenous peoples around the world and to improve cooperation between communities.

Selected abbreviations

ACHPR – African Commission on Human and Peoples’ Rights
AHRC – Asian Human Rights Commission
AU – African Union
CEDAW – Committee for the Elimination of Discrimination against Women
CERD – Committee on the Elimination of Racial Discrimination
CESCR – Committee on Economic, Social and Cultural Rights
CRC – Convention on the Rights of the Child
ECOWAS – Economic Community of West African States
FGM – Female Genital Mutilation
HRW – Human Rights Watch
IACHR – Inter-American Commission on Human Rights
IACtHR – Inter-American Court on Human Rights
ICC – International Criminal Court
ICG – International Crisis Group
IDPs – internally displaced people
IMR – Infant Mortality Rate
MDGs – Millennium Development Goals
MMR – Maternal Mortality Rate
NGO – non-governmental organizations
OECD – Organisation for Economic Co-operation and Development
OHCHR – Office of the High Commissioner for Human Rights
OSCE – Organization for Security and Cooperation in Europe
UNAIDS – UN Programme on HIV/AIDS
UNDP – UN Development Programme
UNEP – United Nations Environment Programme
UNESCO – UN Education, Science and Culture Organization
UNHCR – UN High Commissioner for Refugees
UNICEF – UN Children’s Fund
UNPO – Unrepresented Nations and Peoples Organization
UPR – Universal Periodic Review
USCIRF – US Commission on International Religious Freedom
WHO – World Health Organization

Contributors

Maurice Bryan (*Americas*) is a Caribbean-born writer and communications consultant with a special focus on the use of information technology in a rights-based approach to social and economic development and cultural processes. He has worked in over 30 countries in Latin America, the Caribbean, Asia and Africa, and currently spends most of his time in Central America.

Carla Clarke (*Litigating indigenous peoples' right to health*) is MRG's Legal Cases Officer. She is a qualified lawyer who has worked in both the government and NGO sectors. She holds an MA in Human Rights from Essex University.

Jack Dentith (*Turkey*) is a writer and researcher based in London, UK. Trained in the anthropology of development, his research focuses on the transition to sustainable and equitable economics.

Nicole Girard (*Minority women's vulnerability to HIV/AIDS in South East Asia*) is the Programme Coordinator for the Asian component of MRG's Minority Realities programme. She has been researching and writing on issues facing minority communities in Asia for 10 years.

Katalin Halász (*Europe*) is a researcher, writer and activist with expertise in anti-discrimination legislation, minority rights, Roma rights and racism as a crime. Over the last decade she has worked for national and international human rights organizations in Hungary, Germany, India, Belgium and the UK, and at the European Court of Justice in Luxembourg. She is currently undertaking a PhD in Visual Sociology at Goldsmiths College, University of London, on the representation of race and ethnicity in contemporary visual arts.

Emily Hong (*East Asia*) is a writer and trainer currently pursuing a PhD in anthropology at Cornell University. Emily has spent more than four years in Thailand, including on the Thai–Burma border, working as a trainer and training adviser to minority rights activists from the region, and as a campaigner for Burma's democracy movement-

in-exile. Her recent research focuses on the interplay between culture and rights, the local strategies of minority and indigenous human rights defenders, and corporate human rights abuses.

Hanan Hammoudeh (*Middle East case study*) was a Conflict Prevention Intern at MRG and is a candidate MSc Human Rights at the London School of Economics. Previously she has worked in human rights, democracy development and co-existence ventures.

Paul Hunt (*Foreword*) is a Professor of International Human Rights Law at the School of Law, Essex University, UK. He served as a member of the UN Committee on Economic, Social and Cultural Rights (1999–2002) and UN Special Rapporteur on the right to health (2002–2008). The UN has published his human rights reports on a range of issues including access to medicines, water and sanitation, mental health and sexual and reproductive health.

Paige Wilhite Jennings (*West and Central Africa*) has worked with inter-governmental organizations and NGOs in Central Africa, Central and South America and the Caribbean.

Mark Lattimer (*Peoples under Threat*) is the Executive Director of MRG. Formerly he worked with Amnesty International. Recent publications include (as editor) *Genocide and Human Rights* (Ashgate 2007).

Corinne Lennox (*Addressing health inequalities in the post 2015-development framework*) is a Senior Lecturer in Human Rights at the Institute of Commonwealth Studies, University of London and Associate Director of the Human Rights Consortium, University of London. Her research focuses on minority and indigenous rights protection and on human rights and development. She has worked as a human rights practitioner and consultant, including for MRG, the UNDP and the OHCHR.

Irwin Loy (*South East Asia*) is a multimedia journalist and editor based in Phnom Penh, Cambodia, where he focuses on human rights and development issues. He has filed news and feature

reports from around the South East Asia region for international media.

Farah Mihlar (South Asia) has worked as a journalist covering South Asia for over ten years. Since 2004 she has worked on human rights, including at the UN Office for the High Commissioner of Human Rights. She currently works as Conflict Prevention Coordinator at MRG.

Daniel Openshaw (*Central Asia*) is Press and PR Officer for the Royal College of General Practitioners in London, UK, and a freelance researcher and writer. He was previously a Research Assistant at MRG where he worked on the Central Asia chapter and others, for *State of the World's Minorities and Indigenous Peoples 2012*. He holds an MA in Chinese Studies from the School of Oriental and African Studies, University of London.

Audrey Prost (*South Asia case study*) is a senior lecturer at University College London's Institute for Global Health, and has been working with Indian civil society organization Ekjut since 2008.

Soumendra Sarangi (*South Asia case study*) is a doctoral candidate in Anthropology at Utkal University, India, and partners with Ekjut for his research.

Said Shehata (*Middle East and North Africa*) is an expert on Islamic issues in the Middle East and Europe. He has published academic papers and newspapers articles on Islam and politics in the Arab world, and is a former lecturer in Middle East Politics and International Relations at the London Metropolitan University. He has worked as a consultant for MRG's Egypt and the Middle East programmes.

Carolyn Stephens (*Improving indigenous maternal and child health*) is Professor of Ecology and Global Health of the National University of Tucumán (UNT), based in Argentina, and is UCL Honorary Professor of Ecology and Global Health Equity at the UCL Institute of Health Equity. She is an environmental and social epidemiologist working on health equity, environmental sustainability and human rights. She is Director

of the Amazonia-Yungas Observatory of Biodiversity, Indigenous Health and Equity, and has worked for over 25 years with low-income communities in Asia, Africa and Latin America. She has advised UN agencies, national governments and NGOs on health equity, rights and environmental sustainability. She holds the Royal Society Kohn award for science communication, and is on the editorial board of six international journals.

Irina L Stoyanova (*Russia case study*) is a researcher, writer, and educator whose work focuses on indigenous peoples' rights and activism, sustainability, and international environmental policy. The Circumpolar North region, in particular the indigenous peoples of Siberia and the Saami of Scandinavia, has been a special interest of hers. She has worked with the Rainforest Foundation, The Nature Conservancy, MRG and the UN Permanent Forum on Indigenous Issues.

Prasanta Tripathy (*South Asia case study*) is the Director of Ekjut and an Ashoka Fellow.

Inga Thiemann (*Southern Africa*) is a human rights campaigner and researcher on the issues of gender and racial discrimination, as well as sexual violence. She is a PhD candidate at University College London, working on human trafficking. Inga holds postgraduate qualifications in Advanced International Studies (Dipl.) from Johns Hopkins University SAIS, and International Peace and Security (MA) from Kings College London.

Beth Walker (*SWM Editor*) is former Commissioning Editor at MRG. She is currently an editor at chinadialogue, an English-Chinese bilingual environmental website. Her work focuses on water and sustainable development on the Tibetan Plateau and the rivers that originate there. Beth has worked in Beijing and Shanghai in China, and for an HIV/AIDS NGO in Yunnan province. She studied Chinese at the University of Oxford.

Laura A. Young (*East Africa*) is an attorney and independent consultant focused on human rights and rule of law in Africa, with specific expertise in gender, social inclusion and governance in transitioning states.

Jacqui Zalberg (*Oceania*) is a human rights lawyer who has worked on a range of international indigenous rights cases in a variety of international and domestic forums. This has included working for the UN Indigenous Peoples and Minorities Unit and the US-based NGO EarthRights International. She has also been engaged as a legal adviser to the UN Special Rapporteur on the rights of indigenous peoples, and founded and coordinated the Human Rights Law Clinic at the Law Faculty of the Humboldt University, Berlin.

Holly Ziemer (*Mental health care for survivors of torture and conflict*) is the Director of Communications for the Center for Victims of Torture. Prior to this, Holly served as Director of Communications for the Minnesota Smoke-Free Coalition and also worked as an Account Supervisor for the public relations firm Shandwick International (now Weber Shandwick), and as Director of Communications for Minnesota Attorney General Hubert H. Humphrey III. She has a background in journalism, having worked as an associate producer for several PBS Frontline documentaries and has written for various print media.

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Minority Rights Group International

Minority Rights Group International (MRG) is a non-governmental organization (NGO) working to secure the rights of ethnic, religious and linguistic minorities and indigenous peoples worldwide, and to promote cooperation and understanding between communities.

Our activities are focused on international advocacy, training, publishing and outreach. We are guided by the needs expressed by our worldwide partner network of organizations which represent minority and indigenous peoples.

MRG works with over 150 organizations in nearly 50 countries. Our governing Council, which meets twice a year, has members from nine different countries. MRG has consultative status with the United Nations Economic and Social Council (ECOSOC), observer status with the African Commission on Human and People's Rights, and is registered with the Organization of American States.

MRG is registered as a charity and a company limited by guarantee under English law. Registered charity no. 282305, limited company no. 1544957.

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www.minorityrights.org

Minority Voices Newsroom

An online news portal that allows minority and indigenous communities to upload multimedia content and share their stories:

www.minorityvoices.org

Peoples under Threat map and Directory of minorities and indigenous peoples

Visit MRG's online interactive *Peoples under Threat* map where you can view and compare detailed country information on the world's minorities and indigenous peoples:

www.peoplesunderthreat.org.



State of the World's Minorities and Indigenous Peoples 2013

Events of 2012

In almost every country in the world, minorities and indigenous peoples suffer greater ill-health and receive poorer quality of care than other segments of the population. They die younger, face higher rates of disease and struggle more to access health services compared to the rest of the population. More often than not, this ill-health and poor healthcare is a symptom of poverty and discrimination. At the same time, numerous grassroots initiatives have emerged during recent years. This year's edition of *State of the World's Minorities and Indigenous Peoples* presents a global picture of the health issues experienced by minorities and indigenous communities, features country profiles and case studies, and makes recommendations for addressing these key issues.

