



Alaska (US)

CANADA

NORTH
PACIFIC

UNITED STATES

ATLANTIC
OCEAN

Hawaiian Islands (US)

MEXICO

CUBA

DOMINICAN REP.

Puerto Rico (US)

BELIZE

JAMAICA

HONDURAS

GUATEMALA

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 Kallawayaya 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 Kallawayaya 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 Kallawayaya 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 Kallawayaya 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 Kallawayaya 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 Kallawayaya 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 Kallawayaya 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: Kallawayaya 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. ■

Endnotes

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