MOTHERS ON THE MARGINS

Improving indigenous people's maternal health

HEALTH POVERTY ACTION

CONTENTS

Health Poverty Action works for a world in which the poorest and most marginalised enjoy their right to health.

Written by Sarah Edwards.

Design by RevAngel Designs.

Published June 2010

Health Poverty Action
Ground Floor, 31-33 Bondway
London SW8 1SJ

Tel: 020 7840 3777

www.healthpovertyaction.org

Charity number 290535

MOTHERS ON THE MARGINS

PREFACE

Indigenous women's lives and livelihoods are increasingly under threat from poverty and marginalisation. Nowhere are the effects more starkly seen than in the experiences of pregnant women and new mothers from these communities. Each year tens of thousands die for a lack of appropriate health care.

This report suggests a radical and positive strategy for providing indigenous mothers with the health care they need. Rather than imposing Western medical practice from the outside, it builds on the experience of indigenous people, their holistic understanding of health, and community-led approach to life-events like pregnancy and childbirth.

It recognises that traditional birth attendants (TBAs) and Western medical professionals have much to learn from each other. By bringing their expertise together in a spirit of mutual respect, solutions can be developed which are highly cost-effective, and work with the grain of indigenous cultures.

Across the world Health Poverty Action programmes are demonstrating the value of these simple but effective approaches, rooted in local community experience. With political will and adequate resources, they could transform the lives of millions of mothers worldwide.

Simple solutions that often make a huge difference:

Provide culturally appropriate birthing facilities so more births are attended by skilled health workers. Women in rural Ayacucho, Peru, face some of the country's highest maternal death rates. In 1999 only 6% of births in the Santillana district of Ayacucho took place at a health clinic. Through a programme of introducing culturally appropriate facilities in the health clinic, like allowing women to squat rather than lie down, and having health staff speak the local language, by 2007 this figure had soared to 83% of births.

Train members of the community who already have a role in advising and assisting pregnant women. Abeba is a Traditional Birth Attendant in a pastoralist area of South Omo, Ethiopia. Abeba's training means she can give women advice during pregnancy, and direct them to the clinic if their labour becomes complicated. Abeba is well known by both her community and government health staff for being an excellent birth attendant.

Address the current huge 'democratic deficit' in indigenous peoples' and cultural minorities' involvement in political processes at all levels. In Guatemala the Indigenous Parliamentary Forum provides a national voice for indigenous communities, representing concerns to Parliament and calling on the international community for a focus on development with indigenous people.

1. INTRODUCTION

"Indigenous individuals have an equal right to the enjoyment of the highest attainable standard of physical and mental health."

United Nations Declaration on the Rights of Indigenous Peoples, Article 24.2

Across the developing world, maternal health tells a shocking tale of preventable deaths and complications. Until recently, over 500,000 women were reported to die each year through pregnancy-related causes, 99% of these in developing countries. New figures out recently suggest this figure may have fallen to around 343,000, which though good news is still scandalously high. At the same time, this masks large variations within countries, with little or no progress being made within specific people groups.

Indigenous women are particularly at risk of complications and death before, during or immediately after childbirth, and their children are more likely to die in infancy.[1] It is vital to address the health of indigenous mothers. The global efforts to meet the Millennium Development Goals by 2015 provide a critical opportunity to do this, and simple, effective solutions already exist.

The Millennium Development Goals were created in 2000 when the international community came together to discuss what could be done in the new century to tackle extreme poverty worldwide. The eight promises that emerged have been much criticised, for example for not being ambitious enough. Most are widely off-track from being met by the target date of 2015. However they do represent a real breakthrough in international collaboration towards common goals to deal with poverty. The fifth goal aims to improve maternal health, by reducing the numbers of women who die through pregnancy-related causes, and by achieving universal access to reproductive health.

Nevertheless, the MDGs are flawed, both in intent and implementation. They do not put the rights of the poorest and most vulnerable at their core. Average, numerical targets for reducing poverty and tackling challenges such as maternal health lead to a focus on reaching the largest numbers of people, and therefore often the easiest to reach, like large urban populations or mainstream groups.

Indigenous people or from other cultural minorities are often marginalised from the political and economic processes of their own countries, and experience the worst poverty and health outcomes both nationally and globally. But because of the focus of the MDGs on overall targets, rather than on equity and reaching the most vulnerable, there has not been a concerted effort to improve the health and lives of these people. In fact there is extremely limited information on how much their lives have been affected by the development efforts of the last decade. The indications are not good.

The MDGs are also based on a particular understanding of poverty, development and health which ignores other worldviews such as those held by indigenous people and cultural minorities:

> "By failing to ground the goals in an approach that upholds indigenous peoples' individual and collective rights, the MDGs fall short in addressing the health disparities that persist between indigenous peoples and other poor, marginalized groups... [T]he goals do not consider the indigenous concept of health, which extends beyond the physical and mental well-being of an individual to the spiritual balance and well-being of the community as a whole.
>
> *State of the World's Indigenous Peoples, UN 2009, p156*

The UN MDG summit in September 2010 is an attempt to get the goals back on the road, with just five years to go, and against the backdrop of continuing global economic turbulence. It will not be easy but the needs of the poorest must be prioritised. The goal to improve maternal health urgently needs to focus on the rights of indigenous peoples and other cultural minorities and the actions, led by communities themselves, which can make a lasting difference. If this summit and wider international efforts to tackle poverty are to be judged a success, these communities must move centre stage.

2. CONTEXT

Improving the health of pregnant women and new mothers is one of the eight MDGs and is outlined opposite.

This goal is massively off-track across developing world populations as a whole, with at least 340,000, and possibly more than 500,000, women dying each year through pregnancy related causes.

It is widely accepted that the MDGs are much further off-track for indigenous peoples and other cultural minorities than for mainstream populations. For example, infant mortality can be up to ten times higher, with much lower rates of prenatal care for pregnant women and much higher rates of poor sanitation than among the rest of the population. Even in wealthy countries indigenous people face serious health disadvantages of all kinds, from rates of maternal and child mortality to rates of HIV or diabetes.

While disaggregated data on maternal health is scarce, Honduras provides a good example of maternal health inequality. Though maternal mortality rates were successfully cut by 38% between 1990 and 1997, there are huge disparities. The maternal mortality rate amongst the indigenous community stands at 255 deaths per 100,000 births, compared with a much lower rate of 147 per 100,000 births in the non-indigenous population.[2]

MDG 5: Improve maternal health

Target 5a: Reduce by three quarters the maternal mortality ratio

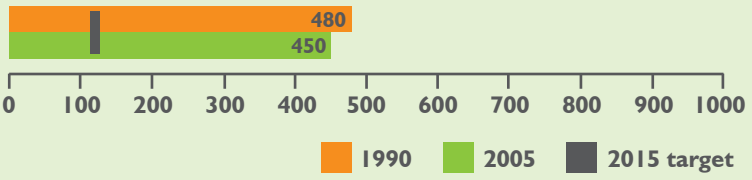
- 5.1 Maternal mortality ratio
- 5.2 Proportion of births attended by skilled health personnel

Target 5b: Achieve, by 2015, universal access to reproductive health

- 5.3 Contraceptive prevalence rate
- 5.4 Adolescent birth rate
- 5.5 Antenatal care coverage
- 5.6 Unmet need for family planning

Maternal deaths per 100,000 live births, 1990 and 2005

Developing regions



Source: UN Millennium Development Goals report 2009

In Guatemala, the gap between indigenous and non-indigenous population's maternal health is shown in a number of ways. Fertility rates are 4.5 for indigenous woman versus 3.1 for non-indigenous women. Contraceptive methods are used by over 60% of women from mainstream society, but only 40% of indigenous women. Importantly, 70% of births by non-indigenous women are attended by a doctor or nurse, compared to just 29% of births by indigenous women.[3]

Where data by ethnic group is not available, regional differences can be indicative in areas where indigenous peoples are highly concentrated. In the northeast of Cambodia, it is recognised that the indigenous people of Ratanakiri Province have a significantly poorer health status than other Cambodians. Child mortality rates in Ratanakiri province are the highest in Cambodia with infant mortality at 187 per 1000 births. This is twice the national average of 95 per 1000 births.[4] Experience from Health Poverty Action's work in the province indicates that maternal mortality in the province is also high, though there are no official statistics on this.[5]

"The way doctors treat us here and in any place, even in Managua, we are discriminated against because we are Miskitu…we sometimes say that pregnant women have a foot here and the other in the cemetery because anything can happen during labour."

Patricia Zacarias – IMATWA, local organisation in Nicaragua

As the least likely MDG to be met, the maternal health of indigenous communities is of particular concern. What do we mean by indigenous people and other cultural minorities, and what specific issues must be taken into account when exploring their health and well being?

Who are 'indigenous people'?

There are an estimated 370 million indigenous people in more than 70 countries. These groups maintain more than 5,000 languages and cultures.

The definition of 'indigenous' is debated; indeed in some countries the very existence of indigenous people is denied altogether. There is no universally accepted definition, although it is often used to denote a group of people with a historical link to a particular region, with a distinct culture, language, community structure and self-identification.

Anthropologist Ken Kempe defined indigenous communities, peoples or nations as *"a non-dominant group of people with a shared history, language and culture residing in a common geographical area. Indigenous people are… non-state people not participating in an industrial mode of production and are thus vulnerable in relation to modernisation and the state"*.

This report talks about indigenous women and those from other cultural minorities, acknowledging that some of the ethnic or cultural communities who would not identify themselves as 'indigenous' still face the same challenges and hurdles in accessing their right to maternal health.[6]

Well being means that my body and mind are happy and well and that I have a good appetite, that I eat and sleep well and have no problems in the family or in the village.

Cham Heb, mother, Tampoeun ethnic group, Cambodia

Feeling well is to feel well with the family, being with friends, having food; and you're well when you don't have any sickness.

Lucilia, aged 14, K'iche' ethnic group, Guatemala

Proper houses, water and nice clean clothes would make me happy and is what I need to be well.

Jamba, traditional leader, San ethnic group, Namibia[7]

Indigenous communities and 'health'

Many indigenous communities have a very different concept of health to mainstream social groups. Often their idea of health is not individual, but a holistic concept which encompasses the collective well-being of their community and ecosystem. For indigenous people the idea of health is often bound up with the harmony of the community and their natural environment.

This holistic understanding of health resonates with the international consensus that to address health, the broader issues that impact upon health need to be tackled, such as water and sanitation, nutrition, education, employment opportunities and social exclusion.[8]

Indigenous people also have different approaches to dealing with illness. When possible, many will first seek traditional healing, and then seek 'other' (western) treatment when advised to by a healer. Often a pragmatic combination of traditional and 'western' approaches to health and well-being is used. They may seek spiritual solutions, use local herbal remedies, or get treatment from a private or state health service provider. Sometimes 'western' treatment is sought for diseases that have only recently arrived in their communities and for which traditional remedies may not exist.

A crucial factor is the way indigenous women understand and deal with health needs. Indeed, understanding cultural practices is essential in finding solutions. To bring about real improvement, outsiders must work with traditional structures and practitioners and not try to impose solutions. Indigenous women need to be empowered to make their own decisions about the health services they want.

On the margins

Indigenous women are particularly marginalised, facing multiple layers of discrimination based on being poor, women and indigenous. Women are disproportionately affected by poverty, and may have little or no say in decisions affecting their lives. As indigenous people, these women and their health are increasingly fragile. Many have lost access to sources of traditional medicine and age-old livelihoods when private companies or government projects have started to operate on their land. Logging, mining, or the building of dams can make land uninhabitable, depriving communities of crops, plants and traditional medicines and polluting water sources.

Indigenous women are also largely excluded from political processes, through gender discrimination as well as discrimination against their communities, and therefore lack the voice to make their own needs and demands heard. Efforts to address indigenous people's maternal health must also therefore address this 'democratic deficit'.

Funding health systems

Indigenous people's maternal health is also at risk because of the huge funding gaps in providing health services in developing countries. The World Health Organisation (WHO)'s Commission on Macroeconomics and Health has calculated that between $27 and $38 billion extra is needed every year to meet the health-related MDGs.[9] This is equivalent to international donors multiplying their current aid commitments for health by five times.

This in turn is shaped by macroeconomic factors including advice and conditions set by international financial institutions, which lead to cuts in social spending; a lack of sustainable, predictable aid from international donors; and the limited ability of developing countries to raise money domestically. Instead of encouraging low tax regimes and low social spending, donors could help countries to improve taxation of wealthy individuals and companies – which would be more sustainable and increase accountability between governments and citizens.

Cost of health services is a factor that further marginalises indigenous people in different ways. In the past, pressure from bodies like the World Bank and International Monetary Fund has encouraged governments to charge people fees for health care. This prevents poor communities, including indigenous groups, from accessing care.

Moreover, the cost of providing health services in areas where indigenous people live is often higher than in majority communities, as they live in remote, sparsely populated regions. Where finance is short, governments and donors emphasise the need for cost effectiveness and tend to focus on areas where costs are lower, further excluding indigenous people. However, as this report sets out to demonstrate, healthcare that effectively reaches indigenous people and other cultural minorities does not need to be hi-tech or expensive. The seeds of change can be found in the communities' own approach to health.

Indigenous woman and child in Cambodia

3. MAKING HEALTH SERVICES WORK FOR INDIGENOUS WOMEN

Indigenous women's health is in a fragile state. Environmental degradation, contact with 'outsiders' bringing communicable diseases and economic and political marginalisation have all contributed to a situation where huge disparities exist between their health and that of the mainstream society.

Cultural barriers are often the biggest obstacles to improving the maternal health of indigenous women. For example, it can be a frightening and humiliating experience to be made to give birth lying down, unable to understand the language spoken by medical staff and with family kept waiting outside. In the worst cases this means women dying in childbirth at home rather than using a system that is completely foreign to them and their traditional practices. As a result, many women rely on traditional approaches instead.

At the forefront of measures to address the maternal health of indigenous women, then, is the need for culturally appropriate health services.

Services must be in keeping with their traditions of health and well-being, provided in their own languages and in a culturally appropriate setting. Women should be able to participate in shaping their own healthcare, including antenatal care and delivery. What would culturally appropriate maternal healthcare look like? There are many aspects to this, so here we will just focus on two important areas.

a) Birthing facilities

Indigenous women may not only live some distance from a health centre, but if they make the trip they may find themselves discriminated against by health professionals who do not speak their language or may hold strong prejudices about them.

Sometimes women find that practices in hospitals go completely against their culture. They and their families often have more confidence in traditional birthing practices than in 'modern' medical techniques.

Indigenous maternal health in Nicaragua

"I am from the North Atlantic Autonomous Region of Nicaragua, where indigenous and ethnic communities have preserved their languages and practices. We see health in an interconnected way: if you do not own your land, if you do not have water, or adequate housing, or spare food, you cannot expect your health to be good.

"The Ministry of Health in Nicaragua has a very vertical approach to working with indigenous people in their service delivery system. They look at individuals first, whereas for us it is the other way around – you have to address the community first. The individual is still important of course, but as a member of a family and a community, not alone. This difference in perspective means the impact of the Ministry of Health's health programmes is limited.

"We are working hard to establish a health system model which addresses indigenous people's real needs, like the Miskitu woman pictured here. For example we're introducing a model for safe motherhood which is appropriate to the indigenous population. We went to the people, we asked them how they wanted to be attended and prepared guidelines for antenatal care and birth attendance, guidelines for Traditional Birth Attendants and health committees. We are not saying that what the Ministry of Health is doing is wrong, yet we need to include indigenous people's perceptions of the world and make the links between traditional practices and western care."

Florence Levy, Health Poverty Action's Country Director for Nicaragua

Indigenous birthing practices: Peru

Women in rural Ayacucho, Peru, face some of the country's highest maternal death rates. In 1999 only 6% of births in the Santillana district of Ayacucho took place at a health clinic.

We found that a series of cultural barriers were preventing indigenous women from using the health clinics. Health workers did not speak the indigenous language, Quechua. They prevented husbands and other relatives from being present in the delivery room, made women wear hospital gowns instead of their own clothes and made them give birth lying down on a table instead of in their normal standing or squatting position. They also discarded the placenta, when the traditional practice is for it to be given to the family to be buried.

A concerted effort was made to change delivery services at a clinic in the Santillana district. This included ensuring health workers spoke Quechua, letting relatives attend the birth, setting up vertical birthing facilities so women could stand or squat, and making other changes based on indigenous traditions.

By 2007, 83% of births were taking place at the clinic. A report from the World Health Organisation in 2009 reported that the project in Ayacucho demonstrated how indigenous women with little formal education do want professional help giving birth, and will use it if they are treated with respect at clinics.[10]

Peru's Ombudsperson's report[11] in 2008 stated that 80% of the rural health centres it visited that were meant to provide vertical birthing facilities did so, showing the improvement in the cultural adaptation of health facilities. However, health workers and organisations told a recent Amnesty International investigation that training in this technique is still not widespread enough.[12] The Ombudsperson's report also stated that more than 45% of staff interviewed who should have known about the technique had not received training on its application. This is despite government policy requiring respect and support for cultural birthing practices.

For example, Mayan women in Guatemala, and other indigenous women in Latin America, usually give birth in a crouching position. The woman supports herself with a rope strung from the rafters or in the arms of her spouse. Instead of painkillers, a woman is also helped by putting her braided hair between her teeth and biting down on it.

It is important that positive or neutral cultural practices are acknowledged and incorporated into government antenatal and birthing practices and guidelines, to make officials and health workers aware of these practices. It is also important to institutionalise traditional birthing positions and the role of Traditional Birth Attendants (TBAs) and other community members, to ensure women's health and wellbeing. This includes what happens at health facilities, but goes beyond it to also include, for example, transporting women during emergencies.

Guatemala is piloting an alternative method of maternal healthcare: Casas Maternas (literally "maternal houses") run by the state authorities. Women whose pregnancy is high risk or who are from remote outlying districts can come and stay up to 48 hours ahead of the birth rather than returning to their community to await labour. Skilled medical staff are on hand and importantly, a woman's spouse can stay with her, helping to reduce her anxiety at being away from familiar surroundings.

Without serious investment and commitment, changes such as those begun in Peru will struggle to get rolled out across countries. As cultural practices vary, and because trust is such a vital issue, it is also important that each community participates in the identification of cultural barriers and how to remove them, if changes are to have a successful impact.

b) Traditional Birth Attendants

Many indigenous women use TBAs who usually learn their skills from older attendants in the community. When a woman becomes pregnant she chooses a TBA who visits her throughout her pregnancy. When labour starts, she will send for her TBA as this is the person she has been seeing all along. Trained TBAs can look for risk factors and if necessary advise women if they need to go to the health centre to have their baby. Attendants often act as a source of general information and can also be trained to provide advice on topics like nutrition and breastfeeding. Importantly they can also act as an advocate for the women if they go to the health centre, reassuring women and acting as a cultural bridge between them and the health workers.

While attendants generally perform a valuable role, if they are not trained they can unknowingly promote some dangerous practices. For example in Nicaragua it is common for attendants to massage the stomach to try and induce the birth. This can lead to the umbilical cord strangling the baby. Communities that rely on TBAs may find that attendants and local health centres do not cooperate with each other. Attendants may not carry out routine antenatal checks, which can be a particular problem if an emergency arises.

Every woman should have access to skilled help at birth – meaning that trained health workers such as midwives are present with the equipment to cope with emergencies such as providing a caesarean section or blood transfusion. The reality is that in many parts of the world health systems simply don't have the staff or resources to provide appropriate services. Until they do, the training of TBAs will continue to be crucial in providing antenatal care, referring mothers to health centres in an emergency, and reducing deaths related to childbirth. In any case, their role as long-term adviser, accompanier and advocate will remain important.

Abeba, Ethiopia

Abeba is a TBA in a pastoralist area of South Omo, Ethiopia. Before childbirth, Abeba advises pregnant women to work less and not to carry water, grind grain or do anything strenuous. Afterwards, she recommends they have hot drinks, ensure they keep their breasts and babies clean, and avoid putting mud or butter in their hair (this is traditionally used as a red hair dye) because it's unhygienic.

Since receiving training on safe delivery and a delivery kit from Health Poverty Action three years ago, she has delivered over 60 babies. Abeba's safe delivery kit enables her to provide more hygienic conditions for deliveries in her community, which in turn helps to prevent infections for the mother and newborn child.

When a birth is complicated, Abeba tells people to bring the mother to the health centre or mobile outreach camp. Her role there includes helping the mother to feel at ease by translating from Amharic into her own language. She is well known by both her community and government health staff for being an excellent birth attendant. Neither a woman nor baby has ever died during a delivery she has assisted with, which she puts down to the blessing bestowed upon her by the elders in her village. If she sends a message that a vehicle is needed to take a woman in labour to the health centre, health staff do everything they can to get one because they know she wouldn't ask for one unless the woman's life depended on it.

Abeba's story shows how TBAs can be trained to play a positive role in their communities' health.

However, many TBAs are untrained, and ministries of health often do not value their role or invest in training them. One particular area of concern is that, following World Health Organisation advice, many developing countries discourage TBAs from delivering babies. Health Poverty Action does not dispute the fact that, in an ideal world, women would be attended by a skilled midwife at delivery. However, in many parts of the world, this is not currently possible, and no real alternative to TBAs attending deliveries is being offered.

Indeed there has been very little progress in the percentage of births attended by a 'skilled health worker' (an official definition which doesn't include TBAs). While in some countries the situation has improved, the percentage of births attended by a skilled worker in low income countries remained below 50% between 1990 and 2008.[13] More resources are urgently needed to remedy this situation.

Here, we have two health systems, the traditional one and the official one. Indigenous women want to be attended to by TBAs because they share our language and our customs. They are more than birth attendants, they take time to talk to the mother, to listen to her problems and they even help her in the home when necessary. What we want is for the Ministry of Health (MoH) to provide better training for TBAs, in our own language, and to make sure they are recognized within the official system rather than marginalised. Often the MoH fails to identify new TBAs, who in turn are afraid of the MoH, but what we want is that the MoH invite them for training and preparation and integration within the health system.

María Aguaré Uz, TBA, Guatemala

c) Other concerns

- Aside from the provision of appropriate services, **prejudices** towards indigenous people are widespread. These need to be tackled, for example health ministries could provide special training for health workers and make a special effort to recruit people from local communities to work as health workers in those communities.

- **Harmful traditional practices** are forms of violence that have been committed against women in certain communities and societies for so long that they are considered part of accepted cultural practice.[14] These violations include female genital mutilation or cutting (FGM), dowry murder, or so-called "honour killings". They lead to death, disability, physical and psychological harm for millions of women annually, and can have a serious impact on the health of pregnant women and new mothers. This is an area of responsibility that is often neglected by governments and donors yet it is a cultural issue with huge implications for health, and needs to be addressed.

In Ethiopia widespread harmful traditional practices and restricted access to health services cause poor health and high death rates in pastoralist communities. For example, forced abortion may take place where pregnancy has occurred outside of marriage. Here the pregnant abdomen is heavily massaged until the foetus is expelled. To hasten the abortion process, herbal extracts are taken. This process is undertaken by the women themselves or by community members who are considered 'knowledgeable'. Education and dialogue are needed to make communities more aware of the dangers of traditional practices.

- As well as being culturally appropriate, health services must be made physically and financially **accessible** to indigenous communities (as well as other remote and poor communities). This means providing well-equipped and reliably staffed mobile health units in remote areas. Solutions such as regular visits from health workers to the communities, in coordination with local volunteers and traditional healers, can also be an effective way to reach such communities. It also means improving transport links and subsidising travel costs for people in need. And it means removing healthcare fees so people do not have to pay to get the treatment they need. Long-term financial support is vital to tackle these sorts of practical barriers.

This is not just a case of making healthcare more pleasant or acceptable. Cultural barriers actually prevent women using health services, and cost many lives. Addressing these barriers must be a much higher priority for the international community in its efforts to tackle poverty and reduce maternal deaths. Training TBAs or providing culturally appropriate birthing are just two examples of how innovative approaches can draw on cultural practices to create simple, effective solutions.

4. POLITICAL INVOLVEMENT

There is a huge 'democratic deficit' in indigenous peoples' and cultural minorities' involvement in political processes at all levels. Mechanisms to ensure indigenous people can speak out and take part in decisions are urgently needed. One example is the Guatemalan parliamentary forum described below. Indigenous communities must have the opportunity and confidence to articulate their own health concerns and priorities to governments and within processes that seek to engage civil society.

This should include the participation of indigenous peoples at all levels of governance, from local decentralization processes to global standard-setting. Within this, communities should be able to effectively participate in national MDG processes and strategies, as well as related processes such as Poverty Reduction Strategies, so that their rights, needs and priorities are included.

Indigenous politics: Guatemala

Guatemala has been represented as "two countries" – the indigenous and non-indigenous populations continue to be divided socially, economically, and culturally. Statistics are contentious: although held to be a majority of the population by indigenous activists, official census reports claim that only 41% of the country is now indigenous, despite greater fertility rates among indigenous populations. The apparent discrepancy can be explained by the fact that more and more ethnically indigenous people no longer identify themselves with Mayan culture in order to avoid social and economic marginalisation.

That marginalisation continues to be reflected in basic services: Mayans attend school for an average of 2.6 years (rural Mayan women, 1.4 years) whereas non-Mayans attend for almost 6 years on average.[15] In 2002, nearly 70% of Mayan children were malnourished, compared with 36% of non-Mayan children.[16]

As a result, the political visibility of indigenous people in the state remains limited. In the parliament, 13% of deputies (equivalent to our MPs) are Mayan. Only 8% of the country's judges are speakers of a Mayan language. And in government, only 5 of 405 ministers in the last five years have been indigenous.

One response has been the formation of indigenous deputies in the Indigenous Parliamentary Forum. The forum calls on the international community for cooperation in its demands for a focus on development with (not for) indigenous people, including organising programmes by linguistic rather than administrative territory, and employing development field workers who are familiar with the distinct language and culture of the indigenous groups with whom they work. The forum presents demands from indigenous communities to the parliament, based on consultation with those communities, for example rejecting mining activities in areas where they live.

In Ratanakiri province, Cambodia, where most people are indigenous, infant mortality rates are twice the national average.

5. KNOWING THE PROBLEM

The lack of reliable health data in the poorest countries is a significant obstacle to setting priorities and measuring progress. In particular, the full extent of health problems faced by indigenous communities is often unknown. Governments need to improve their information gathering and invest more in research and data collection to accurately capture their situation.

Data is usually not broken down by cultural or ethnic group, so it is not possible to track inequalities between these groups. Support should be given to improving health information systems and conducting nationwide surveys, which provide sufficient detail to enable comparisons between geographic areas or cultural and ethnic groups.

Mechanisms for collecting disaggregated data need to be established, in the context of censuses as well as related to key social indicators, with full and effective participation of indigenous peoples in the process of data collection, processing and monitoring. In some countries this is a controversial step as such data has been used as a tool of oppression, such as in apartheid regimes in southern Africa, although for some governments reluctance can stem from a desire to create a homogenised identity for the sake of national unity. But if data is used to monitor how well governments are reaching communities to implement internationally agreed poverty reduction targets, these concerns should be overcome with due sensitivity.

In order to monitor progress against the Millennium Development Goals, the MDG indicators should have greater equity built into them. The use of median statistics to measure progress in maternal and child health often conceals the fact that the poorest are making slower progress. Progress should be measured by use of indicators which look at the progress of specific groups such as indigenous people, not simply at average national progress. Alongside this, specific complementary indicators for indigenous peoples need to be created.

6. TIME FOR CHANGE

"Reaching the health-related [Millennium Development] Goals is not about national averages. It is about reaching the poor, who are almost invariably the hardest to reach. This is the challenge, and the measure of success."

Margaret Chan, Director General, World Health Organisation, May 2010

The specific recommendations set out below must be put in the context of the major funding needs of all developing countries to meet the MDGs, especially for the poorest. Renewed and increased commitments to long-term, predictable aid, debt cancellation, and innovative sources of finance such as financial transaction taxes, are urgently needed.

Beyond this, much more needs to be done to ensure that developing countries can take ownership of their own development choices, without harsh conditions being attached to aid and loans, and also that they are assisted to better mobilise their own resources.

More attention must also be paid to the connections between all eight MDGs by addressing the cross cutting issues such as human rights, gender equality, social exclusion and environmental sustainability which are vital to achieving the MDGs and which are all relevant to the health of indigenous people and cultural minorities.

Recommendations

There have been some efforts to tackle the inequalities between indigenous and other cultural minority populations and mainstream populations. The UN adopted the Declaration on the Rights of Indigenous Peoples in 2007, which many indigenous people believe will, in time, increase political will to confront the exclusion to which they have been subjected. Certain international and regional bodies, for example the Pan-American Health Organisation, have made progress in listening to the demands of indigenous people. Meanwhile the kinds of creative solutions described in this report, if rolled out in sustainable ways, can and have made a real difference. However huge challenges remain.

The international community must provide funding, advice and, where necessary, pressure to ensure that global agreements and the policies and practices of developing country governments meet their obligations to indigenous people and other cultural minorities on maternal health:

- Culturally appropriate maternal health services must be provided for indigenous communities. These must be in keeping with their traditions of health and well-being, provided in their own languages (with interpreters and translators where needed) and in a culturally appropriate setting.
- Prejudices towards indigenous people must be tackled and health ministries should provide special training for health workers in this regard, so that women feel comfortable accessing maternal health services. Special effort should be made to recruit people from local communities to work as health workers in those communities.
- Maternal health services must be made physically and financially accessible to indigenous communities. This means providing well-equipped and reliably staffed mobile health units in remote areas. It also means improving transport links and subsidising travel costs for women so that cost and distance do not remain a barrier.
- Mechanisms to ensure indigenous people can speak out and take part in decisions are vital. Indigenous communities must have the opportunity and confidence to articulate their own health concerns and priorities to governments and within processes that seek to engage civil society, such as district and regional health commissions and authorities.
- The full extent of maternal and wider health problems faced by indigenous communities is often unknown. The MDGs must take on a greater focus on equity, not least in their measurement. Governments need to improve their information gathering and invest more in research and disaggregated data collection to accurately capture their situation.

This report has set out specific changes that could help improve the maternal health of indigenous and cultural minority communities. The approaches to health found in the west and among indigenous communities are not necessarily opposed. What is needed is a model of healthcare that is culturally sensitive and makes best use of traditional as well as "modern" practice. This will not only be cost-effective, but much more likely to break down the barriers that stop indigenous women seeking the right treatment and adopting safe practices.

The challenge to the international community is that, if we believe in eradicating poverty, if we genuinely want to see a world free from easily preventable death and disease, we must focus on those who are the poorest and most vulnerable in our societies. Mothers and pregnant women from indigenous communities surely fall into this category, and their health and well being must be brought centre stage in a renewed effort to meet the Millennium Development Goals. The solutions are already there – what is needed is the political will to implement them.

Endnotes

1. See Lancet Series on Indigenous Health, Vol. 366 and 367, 2005-6.
2. *Health of the Indigenous Population in the Americas,* Pan-American Health Organization (PAHO), 2006
3. These statistics are from Guatemala's 5th National Survey of Maternal and Child Health 2008-09
4. Cambodia Demographic and Health Survey, 2001, quoted in *Crossing the River and Getting to the Other Side: Access to Maternal Health Services amongst Ethnic Minority Communities in Ratanakiri Province, Cambodia,* Eleanor Brown, Health Unlimited, 2005
5. See for example *Indigenous women working towards improved maternal health, Ratanakiri Province, Cambodia*, Health Unlimited, 2006
6. See for example *Report of the ACHPR Working Group Of Experts On Indigenous Populations/Communities,* African Commission on Human and Peoples' Rights, 2005, p95
7. All quotes from original research conducted by Health Poverty Action and published in *Utz' Wach'il: Health and well being among indigenous peoples,* edited by Fiona Bristow, Health Unlimited and London School of Hygiene & Tropical Medicine, 2003
8. See for example WHO Commission on Social Determinants of Health, 2008
9. *Macroeconomics and Health: Investing in Health for Economic Development,* Report of the WHO Commission on Macroeconomics and Health, 2001. The Commission references the goals on malnutrition, maternal health, child mortality, HIV/AIDS, malaria and other diseases.
10. *Cultural adaptation of birthing services in rural Ayacucho, Peru,* World Health Organisation Bulletin 2009
11. Defensoría del Pueblo, *Informe Defensorial 138: Derecho a una Maternidad Segura: Supervisión Nacional a los Servicios de Ginecología y Obstetricia del* MINSA, 2008.
12. *Fatal Flaws: Barriers To Maternal Health In Peru,* Amnesty International, 2009
13. *World Health Statistics 2010,* World Health Organisation, 2010
14. Definition from UNIFEM www.unifem.org/gender_issues/violence_against_women/facts_figures.php?page=4
15. According to 2002 census, as quoted by Foro Indígena Parlamentario: Kitob'anem ri Nab'e taq Amaq'ib' Pueblos Indígenas y Cooperación Internacional, Diputada Rosa Elvira Zapeta, Cuarta Secretaria de la Junta Directiva, Chi Kaji' Tz'ikin. 10 July 2008
16. According to Informe Nacional de Desarrollo Humano. PNUD 2005, as quoted by Foro Indígena Parlamentario: Kitob'anem ri Nab'e taq Amaq'ib' Pueblos Indígenas y Cooperación Internacional, Diputada Rosa Elvira Zapeta, Cuarta Secretaria de la Junta Directiva, Chi Kaji' Tz'ikin. 10 July 2008

“The way doctors treat us here and in any place, even in Managua, we are discriminated against because we are Miskitu…we sometimes say that pregnant women have a foot here and the other in the cemetery because anything can happen during labour.”

Patricia Zacarias, indigenous Miskitu activist, Nicaragua

To find out more and to get involved in our campaign to improve the lives of Mothers on the Margins please visit www.healthpovertyaction.org/campaigns.

HEALTH POVERTY ACTION