ADDRESSING INEQUALITIES
The Heart of the Post-2015 Development Agenda and the Future We Want for All
Global Thematic Consultation

Health inequities of indigenous peoples and ethnic and cultural minorities –
Turning the tide through the post-2015 development framework

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Abstract

The Millennium Development Goals (MDGs) have been criticised for their average global and national targets and lack of focus on equity and inclusion of the most vulnerable. Their measurement of achievement invites 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 those from cultural and ethnic minorities often experience the worst poverty and health outcomes both nationally and globally. Yet there is a dearth of data specifying inequalities between minorities and majority groups due to lack of disaggregation of household survey data by ethnicity or analysis of proxy indicators such as geographical region. Consequently, strategies to achieve development goals often do not include measures to address these specific inequalities.

This paper analyses how inequality manifests itself for indigenous peoples and ethnic minorities. It specifically focuses on health. The analysis culminates in the proposal of benchmarks for the setting of goals, targets and indicators as well as monitoring and reporting in a post-2015 development framework in order to address the inequalities faced by indigenous peoples and ethnic minorities in a post-2015 development framework.

Putting right ... the huge and remediable differences in health between and within countries is a matter of social justice.¹

1 Introduction

Across the world, indigenous peoples are often marginalised in all areas of societal wellbeing, such as access to water and sanitation, reliable livelihoods or political participation. But the marginalisation and inequities experienced by members of indigenous communities and cultural or ethnic minorities holds particularly true with regard to health outcomes which are affected by these social determinants and are often much worse than among the non-indigenous or majority society. With many countries not recognising their indigenous peoples and/or not collecting data on their health there is a dearth of information on population numbers, morbidity and mortality as well as the causes of ill health, especially in low- and
middle-income countries. Where data is available, however, it shows significant inequalities between and within countries. For example, in maternal health 99% of maternal deaths are recorded in developing countries but this still masks large variations within countries. In Guatemala, the estimated maternal mortality ratio in 2000 was 153 per 100,000 live births, while the figure for the indigenous population was three times higher than for the non-indigenous population.

The global efforts to meet the Millennium Development Goals (MDGs) by 2015 have provided a critical opportunity to also address the health of indigenous peoples and cultural and ethnic minorities. However, not only is one of the health goals – MDG5 on maternal health – the one most off-track. But the MDGs are fundamentally flawed in their consideration of equality and equity. They do not put the rights of the poorest and most vulnerable at their core. Rather, aggregate global targets for reducing poverty and tackling challenges such as maternal health have led to a focus on reaching the largest numbers of people, and therefore often the easiest to reach, like large urban populations or mainstream groups.

Furthermore, as the Lancet and London International Development Centre Commission notes, the MDGs’ “quantitative targets and precise indicators, for all their value in providing measurable outcomes, often fail to capture some crucial elements of goal achievement.” This is the case for qualitative achievements in health systems strengthening, for example. More importantly, however, the fragmentation of the goals into sectoral silos and little utilization of synergies among the sectors have led to an underlying negligence of a holistic understanding of development and health. This, in turn, has meant that a crucial analytical view of the causes of ill health, the social determinants, has been omitted or underexploited.

This paper focuses on the health inequities faced by indigenous peoples and ethnic and cultural minorities and how the design of the post-2015 development framework can create better momentum to address them. In the first chapter we will investigate the social, political and economic context of these inequities and provide a brief overview of the manifestations of health inequities among indigenous peoples and ethnic minorities. In the second chapter we, first, lay down some fundamental principles that need to be reflected in the post-MDGs for inequality to be addressed. Secondly, we propose some practical ways of designing the goals so that indigenous communities and ethnic minorities have a better chance to move out of the margins towards health equity and fulfilling their right to health.

We use the terminology of ‘indigenous peoples and ethnic and cultural minorities’ to reflect the fact that health inequities and their origins are often similar across these groups. However, this by no means implies that the context of health is considered the same across all groups, countries or continents, or that some of these peoples and communities may not have different opportunities to address the health challenges they face. It has to be noted that understanding
of what classifies a group as an indigenous people or who belongs to this group is contested.\textsuperscript{vi}
We follow the loose working definition of Martínez Cobo\textsuperscript{vii}:

\begin{quote}
Indigenous communities, peoples and nations are those which, having a historical continuity with pre-invasion and pre-colonial societies that developed on their territories, consider themselves distinct from other sectors of the societies now prevailing on those territories, or parts of them. They form at present non-dominant sectors of society and are determined to preserve, develop and transmit to future generations their ancestral territories, and their ethnic identity, as the basis of their continued existence as peoples, in accordance with their own cultural patterns, social institutions and legal system. [...]"
\end{quote}

On an individual basis, an indigenous person is one who belongs to these indigenous populations through self-identification as indigenous (group consciousness) and is recognized and accepted by these populations as one of its members (acceptance by the group).

While indigenous peoples are not always a minority in their respective national or sub-national contexts, including a notion of ethnic and cultural minorities takes account of those indigenous groups that are not recognized by their national governments as indigenous peoples, and of ethnic minorities that are outside this definition of indigenous peoples. For the sake of readability, we will in many places only refer to indigenous people(s) but emphasize that the same inequities might equally affect ethnic and other cultural minorities.

Let us also briefly clarify why we mostly speak of inequity rather than inequality. Inequality is a descriptive term denoting differences in health outcomes for individuals and social groups or disparities between men and women. “Inequity, [on the other hand,] means inequality that is unfair”.\textsuperscript{viii} In other words, inequity represents inequalities that are perceived as resulting from social injustices. It therefore raises political questions about social relations related to distribution and what more equitable relationships could look like.\textsuperscript{ix x} In this sense, the use of the term inequity also addresses the wider political economic determinants of health or what can be called the causes of the causes of ill health.

\section{2 Inequalities and inequity in health}

The last decade has seen a surge of research on health inequities, culminating at the global level in the publication of the World Health Organisation’s (WHO) Commission on the Social Determinants of Health’s report “Closing the gap in a generation: Health equity through action on the social determinants of health” in 2008. The Commission collected and evaluated evidence on how health inequalities within and between countries could be reduced and to make policy recommendations for the way forward. They come to the conclusion:
The poor health of the poor, the social gradient in health within countries, and the marked health inequities between countries are caused by the unequal distribution of power, income, goods, and services, globally and nationally, the consequent unfairness in the immediate, visible circumstances of peoples’ lives – their access to health care, schools, and education, their conditions of work and leisure, their homes, communities, towns, or cities – and their chances of leading a flourishing life. This unequal distribution of health-damaging experiences is not in any sense a ‘natural’ phenomenon but is the result of a toxic combination of poor social policies and programmes, unfair economic arrangements, and bad politics.xi

In the current MDGs the most explicit indicators of inequities (MDG1) are based on wealth quintiles, income and consumption. These can be an indication of other inequities but, as the Lancet and London International Development Centre Commission highlights, other factors such as geography or ethnic belonging may have more impact on inequities in health than economic factors.xii For programmatic interventions to address inequities effectively and sustainably it is vital that other causes are as thoroughly considered as economic factors. More importantly, however, a holistic social determinist view of health necessitates better integration of the potential array of future development goals so they can synergise to achieve equity as a goal that is greater than its parts.

2.1 The context of inequalities of indigenous peoples and ethnic minorities

Inequality between indigenous and non-indigenous people or ethnic minorities and majority societies manifests itself in many different ways. For indigenous peoples, today’s inequities often go back to colonization through which they suffered new diseases introduced by the colonizers, lost control over the environments, and thus natural resources and water supplies, they had cared for and sustained over hundreds of years, and were often made dependent on food provision by the colonizers. The introduction of alcohol and tobacco, for example, has also had long-term effects on the health of indigenous people.

Colonization in many cases also destroyed indigenous governance and legal systems, thousands of languages or indigenous rituals. At the heart of this lay deeply rooted social structures of racism which often became institutionalized. Relegation to unproductive lands and deprived towns and cities led to “poverty, undereducation, unemployment, exploitation by unscrupulous employers and landlords, and increasing dependence on social welfare or begging in cities and towns”.xiii These structures have perpetuated in so far that even today indigenous people have little role in political decision-making and don’t have the physical capital to lead a dignified life. Discrimination based on ethnicity is something indigenous people often share with ethnic minorities who in many cases are equally marginalized from the majority societies.
Last not least, colonization came with the introduction of the Western medical system which conceptualizes health as the absence of disease rather than according to a holistic world-view that values well-being within the family and community as much as physical health. The missing embeddedness of cultural world-views in many of today’s health systems, for example when women are not allowed to give birth standing up, is a major factor in health outcomes, especially those of pregnant women and mothers.

A major determinant of health – poverty – is very prevalent among indigenous peoples to this day. As Joji Cariño shows, “the difference [in poverty levels] between the indigenous and non-indigenous is often striking, where, for example in Paraguay, poverty is 7.9 times higher among indigenous peoples, compared to the rest of the population. In Panama, poverty rates are 5.9 times higher, in Mexico 3.3 times higher, and in Guatemala, indigenous peoples’ poverty rates are 2.8 times higher than the rest of the population”.

2.2 Inequalities in health outcomes among indigenous peoples and ethnic minorities and their relationship with the MDGs

As mentioned above, there generally is a lack of data available that truly visualises the huge disparities in health outcomes between indigenous peoples and dominant societies. However, where data has been disaggregated by ethnicity or geographical region it has indicated that on almost all health counts indigenous people and members of cultural minorities are worse off than their non-indigenous counterparts. But this is not only a result of their socio-economic marginalisation and cultural discrimination on the causal side of ill health. Rather, the problem is exacerbated by poor access to healthcare due to barriers that are often caused by poverty, geography, or cultural factors such as language.

For example, in Guatemala, the gap between indigenous and non-indigenous populations’ maternal health is shown in a number of ways. Fertility rates are 4.5 for indigenous women 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.

Sometimes regional differences can be indicative of health inequities 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 are the highest in Cambodia with the infant mortality rate at 187 per 1000 live births. This is twice the national average of 95 per 1000 live births.
In Ethiopia, 99.6 per cent of pastoralist women interviewed by Health Poverty Action in the Bale lowlands had never received any postnatal care. Nomadic pastoralists are often unable to access basic services such as health care because of living in remote areas, migrating regularly with their livestock and having distinct cultures and traditions.

While the MDGs have to be credited with promoting the collection of better data, and national information systems have benefited from investment due to the need for monitoring the MDGs, their focus on overall targets, rather than on equity and reaching the most vulnerable, means there has not been a concerted effort to improve the health and lives of indigenous people and ethnic and cultural minorities. In fact there is extremely limited information on how much their lives have been affected by the development efforts of the last decade.

Monitoring progress towards the MDGs means acquiring data to find out what is happening, where, and to whom. Most countries monitor their progress towards meeting MDG targets through aggregate data, meaning that the data uses averages drawn from the whole population. Variations in health outcomes within countries based on ethnicity are therefore masked, making it impossible to see which communities are most at risk. The MDGs’ numbers-based targets could encourage concentration on those who are the easiest and cheapest to reach and leave the poorest people unaccounted for. Maternal or child mortality or the prevalence of the major infectious diseases could even be worsening among marginalised communities during periods when a country may appear to be making steady progress.

The Lancet and London International Development Centre Commission also argue that narrow and quantitative goals and targets have resulted in overlooking broader qualitative development efforts. In particular, more long-term goals such as the promotion of gender equality require diverse approaches that go beyond reporting equal ratios of boys and girls in education. In health, the selectivity of the targets in specific areas of health has exacerbated the non-integration, inefficiency and unsustainability of vertical interventions. In particular the necessary foundation of strong health systems has been neglected. All of these factors have led to negligence of the social determinants of indigenous health and thus their effect on health inequities.

3 Reflecting equality and equity in the post-2015 development framework

3.1 Some fundamental principles

Any future development framework must adhere to the three principles outlined in ‘Realizing the Future We Want for All’: human rights, equality and sustainability. Human rights principles endeavour to achieve such important goals as equality and non-discrimination as well as rights to health, economic wellbeing or civil and political participation. This is to be
undergirded by accountability, empowerment and the rule of law. The principles of equality and equity need to be embedded in the new development framework as central themes. This is especially important because the current MDGs have often hidden inequalities and pockets of extreme poverty, due to the nature of their reach and reporting mechanisms. Reducing inequalities between women and men, different ethnic groups, people of different ages, sexual orientation or physical and mental ability and in economic terms, promises to enhance the wellbeing of societies and individuals. These principles also resonate with the international community’s commitment to sustainable development which is comprised of the three dimensions of economic development, care for the environment and social wellbeing. It is essential that any mal-perceived right to economic development be balanced by the earth’s environmental carrying capacity as well as the equitable distribution of the benefits of economic activity.

The right of everyone to enjoy the highest attainable standard of health and health equity can only be realized when the conditions in which people are born, grow, live, work and age, that is the social, political and economic determinants of health, are tackled. This requires addressing the causes of ill health through a wide range of policies, such as those on food and nutrition, water and sanitation, education, environmental policies or women’s empowerment. It also points to the need for transformation of those economic and political structures which sustain poverty and discrimination, for example the social status of women, racism or land tenure and access to natural resources. So a new development framework should approach health as a cross-cutting issue that shapes and is shaped by all policies. It is worth highlighting that this will be of reciprocal benefit to other sectors, too: “In addition to the fact that healthy people have stronger cognitive and physical capabilities and, in consequence, make more productive contributions to society, health policy contributes to poverty reduction through the financial protection inherent in universal coverage.”xxii

One consequence of conceptualizing health as determined by a multitude of factors and as a cross-cutting policy issue is that holism or sectoral integration becomes a fundamental operational principle for the design of the post-2015 framework so that synergies between different interventions may be used for greatest impact. The Lancet and London International Development Centre Commission’s suggestion to locate well-being within the triangle of “human development (change in their individual human conditions and resources), social development (change in their social relations and resources), and environmental development (change in their access to and relations with natural and environmental resources)”xxiii is a helpful, higher lever guide to ensure that the post-2015 development framework recognizes the interdependence of different dimensions of development.
3.2 Benchmarks for goal-setting and reporting in a post-2015 development framework

As the UN System Task Team on the Post-2015 UN Development Agenda notes in its Thematic Think Piece on Health “the way goals are defined inevitably influences how the world understands development and the ways in which it can be advanced. Goals are thus interventions in their own right, shaping the meaning of development and influencing resource transfers within and between nations and institutions”. xxiv This reflects that many of the problems associated with the MDGs lie within their design and that we now have the opportunity to learn from those shortcomings for the new framework for development.

In order for our principles of human rights, equality and sustainability as well as holism to be reflected in a post-2015 framework we would like to propose the following benchmarks for the setting of goals, targets and indicators as well as monitoring and reporting.

First, the root causes of poverty and inequality must be brought to the fore and specific efforts taken to address them. This could, for example, be addressed by setting more measurable goals for high-income countries such as in trade or tax policies. A post-2015 framework must thus have universal applicability and not be merely bound to overseas development aid.

Secondly, equity and the right of everyone to health need to be reflected both in terms of equity of opportunity and equity of outcome. xxv That is to say that national and sub-national post-2015 policies need not only create access to health services or educational opportunities but the relevant authorities need to consult and consider a diversity of groups and individuals and provide the necessary resources for their participation in assessing the equity outcomes of interventions. Such a participation target would go a long way in ensuring better integration of any future goals.

Thirdly, in terms of sectoral integration and holism it has been suggested that the post-2015 framework needs to move away from fragmented, exclusively number-based targets and target-based goals to higher-level goals with a number of targets and quantitative as well as qualitative indicators below them. Health Poverty Action has proposed that an overall goal could aim to reduce the number of years lost due to ill-health, disability or early death (disability-adjusted life years, or DALYs). Or, for more simplicity, the goal could revolve around gains in life-expectancy or healthy life-expectancy, the latter of which takes into account morbidity and disability. This could be connected to a range of targets and indicators addressing the broad range of factors that affect mortality and morbidity but which might also be outputs towards other overall goals such as gender equity. One of these targets should be specifically for universal health coverage. While we have noted that health and wellbeing goes much
further than providing health services, nevertheless the provision of and access to these services is a vital component of achieving the right to health for all.

A target and indicators on universal coverage would also embrace equity concerns as the single most effective way of showing the reach of health service coverage across different areas of health and for different groups of a population as well as of financial risk protection.

Regarding the question of what reporting against a new set of goals would have to look like to address inequities of marginalised groups, in particular indigenous and other ethnic communities, it is first of all essential to set the targets nationally or according to local context. The aggregate global targets of the MDGs were unachievable for many countries that started out with higher numbers of people in need. So, if for example, maternal deaths were to be reduced by three quarters this was much bigger a challenge for a country with high mortality rates due to challenging environments such as a post-conflict situation. Countries should also set their own targets for reducing the gaps in health outcomes between different groups of their societies so that resource allocation may go towards the most marginalised.

More importantly, it is, secondly, vital that the post-2015 framework requires the disaggregation of data along the major fault lines of inequalities and inequities. The Commission on Information and Accountability for Women's and Children's Health has set a good precedent in proposing a number of essential and optional criteria for the disaggregation of data. Indicators should be reported against the lowest wealth quintile, gender, age, urban/rural residence, geographic location, ethnicity, and, where feasible and appropriate, for education, marital status, number of children and HIV status. These will require major investments in capacity building and national information systems. Through these steps, however, inequities will be made visible and more easily addressable.

4 Recommendations

This paper has examined the historical and socio-economic context and manifestations of health inequities of indigenous peoples and ethnic and cultural minorities. On most accounts, these groups suffer from hugely disparate health outcomes in comparison to non-indigenous or majority societies.

For every person from an indigenous, ethnic or cultural minority background to achieve their right to health and be treated in an equitable manner we have proposed four main benchmarks for goal-setting and reporting in a post-2015 development framework.
1) The root causes of poverty and inequality must be brought to the fore and specific efforts taken to address them. Among other things, a post-2015 framework must have universal applicability and not be merely bound to overseas development aid.

2) Equity of opportunity and outcome: Access to health services or educational opportunities need to be complemented by broad participation in monitoring the outcomes of services. Such a participation target would go a long way in ensuring better integration of any future goals.

3) The new framework should have an overarching holistic aim of improving human wellbeing, moving away from fragmented goals and targets. The health goal could be a reduction in the number of years lost due to ill-health, disability or early death or could revolve around gains in life-expectancy or healthy life-expectancy. This could be connected to a range of targets and indicators addressing the broad range of factors that affect mortality and morbidity but which might also be outputs towards other overall goals such as gender equity. One of these targets should be specifically for universal health coverage.

4) In terms of reporting and monitoring, it is essential to set the targets nationally or according to local context. Countries should also set their own targets for reducing the gaps in health or other development outcomes between different groups of their societies so that resource allocation may go towards the most marginalised.

5) The post-2015 framework requires the disaggregation of data along the major fault lines of inequalities and inequities. Indicators should be reported against the lowest wealth quintile, gender, age, urban/rural residence, geographic location, ethnicity, and, where feasible and appropriate, for education, marital status, number of children and HIV status.

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