

Progress **can** kill

HOW IMPOSED DEVELOPMENT DESTROYS THE HEALTH OF TRIBAL PEOPLES



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‘OUTSIDERS WHO COME HERE ALWAYS CLAIM THEY ARE BRINGING PROGRESS. BUT ALL THEY BRING ARE EMPTY PROMISES. WHAT WE’RE REALLY STRUGGLING FOR IS OUR LAND. ABOVE ALL ELSE THIS IS WHAT WE NEED.’

ARAU, PENAN MAN, SARAWAK, MALAYSIA, 2007

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Introduction:

Land and Life



'You napēpē [whites] talk about what you call "development" and tell us to become the same as you. But we know that this brings only disease and death. The forest is our life and we need it to fish, grow food, hunt, sing and dance and have feasts. It gives life for all. Without forest, there is only sickness.'

Davi Kopenawa Yanomami, Brazil, 2007¹

'I say what kind of development is it when the people live shorter lives than before? They catch HIV/AIDS. Our children are beaten in school and won't go. Some become prostitutes. They are not allowed to hunt. They fight because they are bored and get drunk. They are starting to commit suicide. We never saw that before. Is this "development"??'

Roy Sesana, Ghana

Bushman, Botswana, 2005²

Across the world, from the poorest to the richest countries, indigenous peoples today experience chronic ill health. They endure the worst of the diseases that accompany poverty and, simultaneously, many suffer from 'diseases of affluence' – such as cancers and obesity – despite often receiving few of the benefits of 'development'. Diabetes alone threatens the very survival of many indigenous communities in rich countries.³ Indigenous peoples also experience serious mental health problems and have high levels of substance abuse and suicide. The Pikangikum Indians of Ontario, for example, have a suicide rate nearly 40 times the national Canadian average.

But indigenous peoples have not always been so unwell, and those who live independent lives on their own lands, eating traditional foods, continue to be healthy and strong.⁴ These groups may be poor in monetary terms, but are rich in many other ways. They typically have many of the characteristics that have been found to raise happiness, including strong social relationships, stable political systems, high levels of trust and support, and religious or spiritual beliefs, which give their lives meaning. A study exploring happiness and 'life satisfaction' found a high score among a traditional group of Maasai who had resisted colonial attempts to change their way of life and who had largely avoided the market economy. The Maasai had a similar life satisfaction rating to those on the Forbes list of the 400 richest Americans.⁵

'We are not poor or primitive. We Yanomami are very rich. Rich in our culture, our language and our land. We don't need money or possessions. What we need is respect: respect for our culture and respect for our land rights.'

Davi Kopenawa Yanomami, Brazil 1995.

Tribal peoples who have suffered colonisation, forced settlement, assimilation policies and other forms of marginalisation and removal from ancestral lands almost always experience a dramatic decline in health and wellbeing. Dislocation from their land is almost always coupled with rising illness.⁶ 'In general, the most devastating contact situations seem to have been associated with dispossession from the land' (Kunitz 1994:178).

This report explores the reasons why landless and 'assimilated' tribal peoples today suffer such high levels of physical and mental illness. There are many factors that can tip a group from an independent, healthy life to dependency and early death, but underlying them all is a loss of rights over their ancestral land and poverty created by the loss of an independent livelihood.

Improving indigenous peoples' health cannot be achieved through clinics and medications alone: the major factors causing their poor health are social, economic, political and legal.⁷ International, national and local action is urgently needed to enable indigenous

peoples to reconnect with their lands, rebuild their shattered lives and gain control over their futures.

This report examines the situation of indigenous and tribal peoples at very different levels of contact. This ranges from the recently contacted Jarawa tribe of India's Andaman Islands, whose isolation makes even minor contact with outsiders potentially fatal, to Australian Aborigines who have had contact with outsiders since their lands were first invaded more than 200 years ago. The threats to and needs of these peoples vary enormously. However, the importance of land, and the need to make their own decisions about their own way of life and futures, is fundamental to all tribal people.

WHY DO INDIGENOUS PEOPLE LOSE THEIR LAND?

In many countries indigenous peoples have become a minority with little influence over policies that affect their lives. Their lands may be taken 'in the national interest' for dams, mines, conservation projects, and other schemes which promise 'development' but leave the land's true owners marginalised. Without a strong voice in political processes or recognition of their inalienable legal rights to their lands, it can be difficult – if not impossible – for tribal communities to influence these projects and protect their independence.

In other cases, indigenous peoples are removed from their land, often forcibly, in order to integrate them into national society and bring them 'development'. This often happens when there are valuable resources on or under the land. These policies are frequently born of a

racism towards tribal communities that sees them as 'backward' and in need of being 'brought into the modern world'. Changing these stereotypes and racist attitudes is essential for the long-term health and survival of tribal peoples. Whatever the factors that cause tribal peoples to be removed from their ancestral lands, the physical impacts are often similar: short-term shock and exposure to disease and long-term suffering from chronic mental and physical illnesses.

WERE THEY REALLY SO HEALTHY BEFORE?

There is, understandably, a lack of data on the health of uncontacted tribal groups, but clear patterns can be seen all over the world: independent, mobile peoples who live mostly by hunting and gathering are usually healthier than their settled neighbours who live in crowded, urban environments, eat a 'Western' diet and exercise less.⁸ No indigenous group is free of disease, but isolated tribal peoples are largely well adapted to the parasites and germs to which they have historically been exposed.⁹ 'Past foragers had a healthy way of life, a good diet and physical exercise, virtually no salt, alcohol or tobacco, no pollution, fewer cancers and a life span and child mortality rate not so different to what was observed in Europe a few centuries ago.' (Froment 2001:259)

Child survival rates and life expectancies vary greatly, but are often lower for tribal groups than for rich, Western populations. However, they are typically higher for tribal communities than for their non-tribal, poor neighbours. It is important to make realistic comparisons; when they are settled, tribal peoples do not

suddenly have health statistics comparable to Western averages. 'Although life expectancies of hunter-gatherers are low by modern European or American standards, they compare favourably with expectancies for displaced hunter-gatherers, many subsistence agriculturalists, and impoverished urbanized peoples of the tropics today.' (Dunn 1977:102).

Typically, life expectancies decrease when hunter-gatherers are settled, not increase. Their life expectancies are thought to be lower now than they would have been at the turn of the 20th century because of the negative impacts of outsiders, such as the stealing of land, the depleting of food stocks and the spreading of diseases.¹⁰

The major factor contributing to low life expectancies is commonly a high infant mortality rate. This means that those who survive infancy can expect to live longer than might seem apparent from a statistic of life expectancy at birth.

Looking specifically at infant mortality, there is great variation in rates among different tribal peoples. Where population densities are low, contact with external societies and their diseases is minimal and food is abundant, rates of child mortality are relatively low. Where there has been high exposure to external diseases, vaccination programmes are necessary to protect against epidemics. Among many tribal peoples, child mortality increases when they are settled, especially when highly mobile peoples are moved to crowded, unsanitary camps or shanty towns, as is common. For example, the Onge of Little Andaman Island, who were settled by the government in 1976, experienced a doubling of infant mortality rates in the seven years between 1978 and 1985. This was largely due to malnutrition

following the change from a varied diet of meat, fish, fruits and honey to a diet of government rations, and due to exposure to diarrhoeal diseases.¹¹

Colonial explorers visiting isolated peoples regularly reported how strong and healthy the people were, recording ‘fine teeth’, ‘excellent skin’ and ‘muscular physiques’.¹² But contact with outsiders has brought exposure to new diseases and corrosive changes to the livelihoods and practices that had maintained the health of the community. Historical accounts by some of the first European settlers in Australia note that the Aborigines they met were physically healthy, ‘lively’ ‘active and nimble’, with ‘compleat setts’ of ‘even and good’ teeth.¹³ **The Aborigine population then was around 750,000, although it was rapidly reduced to just over 70,000 by the 1930s.**¹⁴

It is important to note that most of today’s tribal peoples are living in very marginal environments, from the Arctic circle to the Kalahari desert, some having been pushed to these extremes by more numerous, powerful populations. The availability of resources has decreased for even the most isolated people due to loss of land and freedoms. Even the most isolated peoples have often been exposed to diseases and violent contact in the past. The health of many of today’s hunter-gatherer peoples must be assessed in this light.

The Inuit certainly had some health problems before regular contact and sedentarisation, including unusual cancers, but early explorers remarked on the vigorousness and healthiness of Inuit peoples.¹⁵ They had some resistance to illnesses such as arthritis and diabetes

because of their diet, levels of exercise and genetic adaptations. Similarly, there were some common diseases among the Amazonian Yanomami before waves of miners invaded their land. There was tetanus in the soil and viral infections like herpes and yellow fever, but those diseases were at a low level and were rarely fatal.¹⁶ Measles, malaria, whooping cough, influenza, polio, TB, rubella and chicken-pox were among the diseases to which they had no immunity and to which they were first exposed when gold-miners invaded.

By the 1930s colonisation had reduced the Aboriginal population by 90%.

XINGU VALLEY, BRAZIL

IN THE 1960S AND 1970S, BRAZILIAN DOCTORS LED BY DR ROBERTO BARUZZI, MADE DETAILED STUDIES OF THE HEALTH OF INDIANS IN THE PARQUE NACIONAL DO XINGU (PNX) IN BRAZIL’S MATO GROSSO STATE. SOME OF THE TRIBES HAD ALWAYS LIVED IN THE AREA, OTHERS WERE MOVED THERE IN THE 1960S AND 1970S AFTER DISASTROUS EXPERIENCES OF CONTACT ELSEWHERE. THE GROUPS WERE IN INTERMITTENT CONTACT WITH OUTSIDERS, MAINLY GOVERNMENT PERSONNEL, AND MAINTAINED THEIR TRADITIONAL LIVELIHOODS.

BARUZZI’S TEAM FOUND THE INDIANS TO BE IN VERY GOOD HEALTH. THERE WERE FEW EXAMPLES OF ANY ‘WESTERN’ DISEASES: NO DIABETES, NO CARDIOVASCULAR DISEASE, NO HERNIAS, ULCERS OR APPENDICITIS. THIS WAS EXPLAINED BY THE COMBINATION OF CONSTANT PHYSICAL ACTIVITY, TRADITIONAL DIET AND LOW LEVELS OF STRESS. MEN AND WOMEN HAD LITTLE BODY FAT AND WERE IN AN ‘ATHLETIC CONDITION’, CHILDREN WERE ‘WELL NOURISHED’. GUT INFECTIONS – A LEADING CAUSE OF DEATH AMONG POOR CHILDREN IN DEVELOPING COUNTRIES – WERE ‘NOT AN IMPORTANT CAUSE OF MORTALITY IN INFANCY BECAUSE OF PROLONGED BREAST-FEEDING AND THE GOOD NUTRITIONAL STATE OF THE INFANT POPULATION.’

THE TRIBES OF THE UPPER XINGU VALLEY HAD SUFFERED A TERRIBLE MEASLES EPIDEMIC IN 1954, AFFECTING THE WHOLE POPULATION (THEN ESTIMATED AT 600 PEOPLE) AND KILLING 20% OF THEM. SINCE THEN, VACCINATIONS AND A SENSITIVE LOCAL PROVISION OF MEDICAL CARE – WORKING WITH, RATHER THAN AGAINST, LOCAL TRADITIONS AND SHAMANS – HAS HELPED PREVENT FURTHER MASS SUFFERING FROM OUTSIDERS’ INFECTIOUS DISEASES.¹⁷

'What we are really doing is a crime. When I enter into contact with Indians I know that I am forcing a community to take the first step on a road that will lead them to hunger, sickness, disintegration, quite often to slavery, the loss of their traditions, and in the end death in complete misery that will come all too soon.'

Antonio Cotrim, FUNAI (Brazilian government Indian affairs department), 1972



WHAT HAPPENS WHEN ISOLATED PEOPLE ARE FIRST CONTACTED?

Sudden contact with an alien society is devastating to remote tribal peoples, often involving shock, disease and violence, all of which can be deadly.¹⁸ The European invasion of the Americas wiped out 90% of the indigenous population. This devastation was caused partially by violence and slavery, but mostly by a lethal combination of epidemics and shock which led to a decline in total fertility and a loss of the will to live, often resulting in suicides, even of children.¹⁹ The population of what is now Mexico, for example, fell from 20 million in 1518 to 1.6 million in 1618.²⁰

Between 1967 and 1975 one Yanomami community in Roraima, Brazil, was totally wiped out through measles. Other villages in the area suffered a dramatic population decline of up to 70% because of diseases spread by road builders.²¹ A fear of the supernatural forces that could cause such suffering immobilised people. Village life collapsed and suffering was increased by the lack of people able to bring water,

hunt, care for the sick and prepare food.²² Such shock can have direct physical consequences, such as causing miscarriage in pregnant women.²³

In South America, South East Asia and Melanesia, there are some peoples who have deliberately chosen to remain isolated from outsiders, in an effort to save both their health and their ways of life from the impacts of contact. These peoples are incredibly vulnerable to complete extermination by invaders. The Peruvian indigenous federation, FENAMAD, has warned that, for the isolated Indians living upstream of the Timpia, Serjali and Paquiria rivers, 'contact by outsiders with these peoples would constitute a serious threat to their fundamental rights to health, cultural identity, well being and possession of land ... and make possible their extinction as individuals and as indigenous peoples.'²⁴

Importantly, however, first contact has a less devastating impact when people maintain control over their land. 'Indigenous people experienced high mortality from imported infectious diseases mainly when their land was taken and their economic base, food supply and social networks were disrupted. When land was not taken in large amounts by European settlers the death rate was relatively low' (Foliaki and Pearce 2003:406). The Enawene Nawe of Mato Grosso, Brazil, have been able to hold onto most of their land, experienced contact relatively positively and have survived well as a distinct and healthy people.

The European invasion of the Americas wiped out 90% of the indigenous population.

CONTACT MISSIONS IN BRAZIL: THE TRAUMA OF EPIDEMICS

IN THE 1970S, THE BRAZILIAN GOVERNMENT'S INDIAN DEPARTMENT, FUNAI, CONTACTED MANY TRIBAL GROUPS, OFTEN WITHOUT ANY APPROPRIATE MEDICAL CONSIDERATION OR ASSISTANCE. THEY USED GIFTS TO LURE INDIANS TOWARDS 'FRIENDLY CONTACT'. THE PSYCHOLOGICAL IMPACTS OF THE RESULTING EPIDEMICS WERE DEVASTATING:

* THE SURUÍ NUMBERED AT LEAST 363 IN 1971. WITHIN THREE YEARS OF A JOINT FUNAI-MISSIONARY CONTACT PROGRAMME, 193 HAD DIED. A DECADE LATER, THIS TIME OF DEVASTATION REMAINED ACUTELY PAINFUL TO THE SURUÍ: **'EACH PERSON IS DESOLATE AS HE OR SHE COUNTS THEIR DEAD RELATIVES: MANY BROTHERS AND SISTERS, FATHER, MOTHER, CHILDREN, HUSBAND, WIVES'** (BETTY MINDLIN).²⁵

* WITH THE PARAKANÁ INDIANS, INITIAL CONTACTS WERE VERY FRIENDLY, WITH PLENTY OF SINGING AND DANCING WITH THE FUNAI 'ATTRACTION' TEAMS, BUT WAVES OF ILLNESS SOON FOLLOWED, SPREAD BY FUNAI STAFF. IN ONE EPIDEMIC, OVER ONE THIRD OF THE POPULATION DIED. 35 WOMEN WERE FOUND TO HAVE BEEN INFECTED WITH GONORRHOEA, AND SOME OF THEIR CHILDREN WERE BORN BLIND. THIS LED TO THE SACKING OF A NUMBER OF FUNAI WORKERS. IN 1979, 95% OF THE POPULATION WAS STRUCK BY A VIOLENT FLU EPIDEMIC. FUNAI'S RESPONSE TO THE DEATHS WAS TO REPEATEDLY MOVE THE COMMUNITY, FINALLY SETTLING THEM IN ALIEN HOUSING IN A RESERVE, WHERE TRADITIONAL BURIAL RITES WERE BANNED. THE PSYCHOLOGICAL AND CULTURAL DAMAGE WAS CATASTROPHIC.²⁶

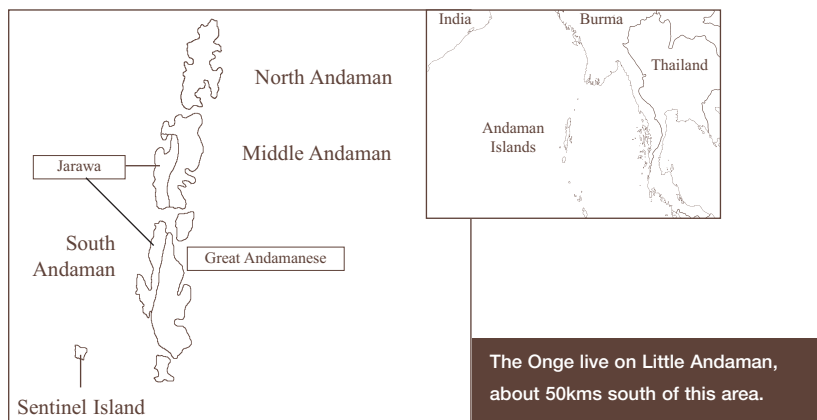
* CONTACT OF THE MATÍS BY FUNAI WAS NO LESS DEVASTATING: **'THE LAST MONTHS OF 1981 WERE PARTICULARLY TRAGIC, COSTING THE LIVES OF SOME 50 MATÍS. THE TRAUMATISED SURVIVORS ABANDONED THEIR HABITATS THAT WERE DISPERSED IN THE FOREST, AND CONGREGATED AROUND THE FUNAI POST ON THE BANKS OF THE ITUI RIVER IN ORDER TO OBTAIN MEDICINES... [THEY SUFFERED] DEMOGRAPHIC AND PSYCHOLOGICAL SHOCK FROM THIS ABSURD, BANAL AND UNNECESSARILY MURDEROUS CONTACT'** (PHILIPPE ERIKSON).²⁷

* THE EXPERIENCE OF THE NAMBIQUARA, WAS, SADLY, TYPICAL: **'MY FATHER SAID THAT BEFORE THE WHITES [CAME] WE HAD HARDLY ANY ILLNESSES. IN 1984 MY FATHER DIED OF A LUNG INFECTION. AT THE TIME OF [THE BUILDING OF THE ROAD] EVERYONE GOT FLU AND MEASLES AND EVERYONE DIED'** (NAMBIQUARA SHAMAN).²⁸



In the 1980s, the World Bank funded a road which cut through Nambiquara land, bringing ranching, mining, logging and disease in its wake. The impact on the tribe was devastating.

DISEASE AND DEVASTATION IN THE ANDAMAN ISLANDS



The Andaman and Nicobar Islands lie off the east coast of India and have been home to several distinct tribes for tens of thousands of years. Administration of the archipelago, first by Britain and later by India, has brought disaster for those tribes with whom they have had the most contact.

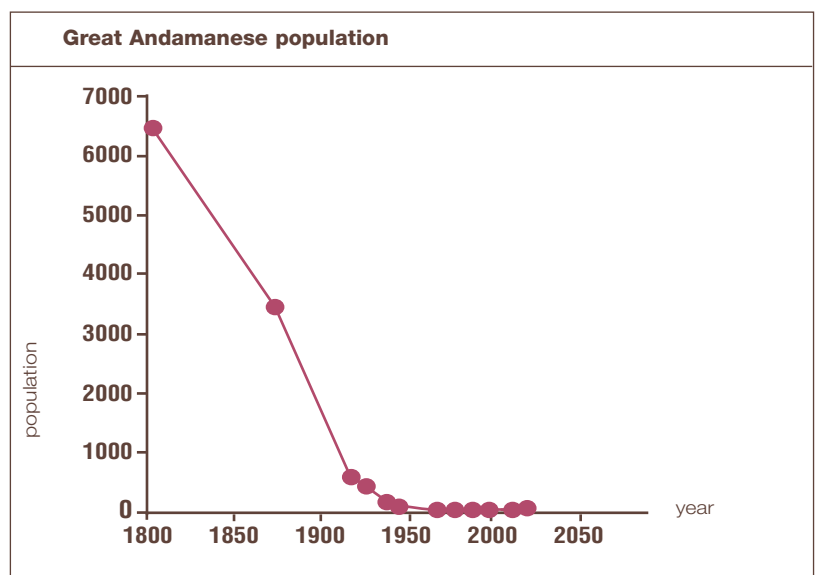
The Sentinelese are self-sufficient hunter-gatherers whose isolated location and aggressive behaviour towards outsiders have saved them from the devastation that has been wrought on their neighbours, the Great Andamanese, whose population is now just 53.

When the British first colonised the Andaman Islands, the Great Andamanese were a healthy people, but with little immunity to diseases such as measles and influenza. Since then, 99% of this tribe have been wiped out through battles with the British, transfer of diseases and the disastrous and cruel policy of taking children from their families to be raised in a children’s home. **Of 150 babies born in the home, none survived beyond the age of two.** In 1970, the surviving Great Andamanese were moved to the tiny Strait Island by the Indian authorities, where they are now totally dependent on the government for food, shelter and clothing, with high rates of alcoholism and tuberculosis.

The Onge of Little Andaman Island have also suffered greatly. Before they were ‘resettled’ by the government, the Onge hunted, fished and gathered on Little Andaman island, and had diets rich in wild boar meat, fruits and honey. From the 1950s, settlers invaded their lands and the government logged their forests. Since being resettled in 1976, the Onge have become dependent on nutritionally-poor government rations, with a drastic impact on child health. Between 1978 and 1985, the infant mortality rate doubled, with the most common cause of child deaths being from diarrhoea, dysentery and malnutrition. The Onge population fell from 670 in 1900, to 169

in 1961, to 76 in 1991. **‘This “resettlement” has set in motion the biological, social and cultural death of the Onge.’**²⁹

The Onge’s neighbours, the Jarawa, have maintained their independence and therefore suffered less through disease and removal from their lands. They are mostly still nomadic and self-sufficient, but they are at increasing risk from poachers and settlers who are continuing to use a road through their territory. The supreme court of India ordered that the road must be closed but, despite government assurances, the road remains open and poachers are not being stopped from accessing the area.





'MEASLES GRADUALLY SPREAD THROUGHOUT THE WHOLE OF THE GREAT ANDAMAN... HALF, IF NOT TWO THIRDS, OF THE WHOLE OF THE ANDAMANESE IN THE GREAT ANDAMAN DIED FROM ITS EFFECTS... THIS EPIDEMIC WAS THE MOST SERIOUS DISASTER WHICH HAS BEFALLEN THE ANDAMANESE, AND OWING TO THE EFFECTS OF IT OUR TREATMENT OF THEM UNDERWENT A CHANGE, ALL ATTEMPTS TO FORCE THEM TO SETTLE DOWN TO AN AGRICULTURAL LIFE WERE ABANDONED...' M.V. Portman, Officer in charge of the Andamanese, 1899

WHAT HAPPENS WHEN THEIR LAND IS TAKEN FOR DEVELOPMENT PROJECTS?

All around the world indigenous people have their land taken from them for economic development projects such as mining, logging and plantations. Such projects are often imposed on the tribal landowners, ignoring their rights to their land. These activities can cause enormous environmental degradation leading directly to the loss of tribal land, hunting grounds, gardens and drinking water. For example, the Kamoro of West Papua have had one billion tons of tailings tipped into their river system from the American and British owned Grasberg copper

and gold mine. Although the company claims that the quality of water passes international standards, even according to their own monitoring data supplied to the government, it breaches legal levels for dissolved copper. Total suspended solids in the Lower Ajkwa River are up to 100 times over the legal limit. The tailings also smother the vegetation causing trees and sago palms, the staple food of the Kamoro, to die. The Kamoro used to use the river for drinking water, fishing, navigating and washing and the forest, which is also being polluted by the tailings, for hunting.³¹



LOGGING AND THE PENAN OF MALAYSIA

THE PENAN OF SARAWAK PROVINCE, MALAYSIA, HAVE ALSO SUFFERED ENVIRONMENTAL DEGRADATION OF THEIR LAND DUE TO LARGE SCALE LOGGING OF THEIR RAINFOREST HOME. THE RIVER HAS BEEN POLLUTED WITH CHEMICALS USED BY THE LOGGERS, OIL, RUBBISH AND SILT. NGOT LAING, 53, CHIEF OF LONG LILIM COMMUNITY, TALKS OF THE PROBLEMS THE LOGGING HAS BROUGHT TO HIS PEOPLE. **'WE HAVE BEEN IN LONG LILIM LONG BEFORE THE COMPANIES CAME IN... IN THE PAST OUR LIFE WAS PEACEFUL, IT WAS SO EASY TO OBTAIN FOOD. YOU COULD EVEN CATCH THE FISH USING YOUR BARE HANDS – WE ONLY NEEDED TO LOOK BELOW THE PEBBLES AND ROCKS OR IN SOME HIDING HOLES IN THE RIVER. THE PEOPLE ARE FREQUENTLY SICK. THEY ARE HUNGRY. THEY DEVELOP ALL SORTS OF STOMACH PAINS. THEY SUFFER FROM HEADACHES. CHILDREN WILL CRY WHEN THEY ARE HUNGRY. SEVERAL PEOPLE INCLUDING CHILDREN ALSO SUFFER FROM SKIN DISEASES, CAUSED BY THE POLLUTED RIVER. UPPER PATAH USED TO BE SO CLEAN.'**

AND MOTHER PAYA DING, 29, FROM LONG SAYAN VILLAGE, TALKS ABOUT THE DIFFICULTIES OF LOOKING AFTER HER CHILDREN SINCE THE COMPANIES CAME. **'MY BREAST MILK DRIES UP SOMETIMES BECAUSE I DO NOT GET ENOUGH FOOD. SO I TRY TO LOOK FOR UBUT [SAGO PALM HEART] AND BOIL IT WITH WATER TO FEED THE BABY. BUT EVEN UBUT IS DIFFICULT TO FIND. ALL HAVE BEEN DESTROYED BY THE COMPANIES. LOOK AT MY BABY. HIS SCALP HAS THIS INFECTION. IT IS SCALY AND YOU HAVE THESE LITTLE BIJI (RASHES) GROWING. FOR TWO WEEKS ALREADY. IT IS PAINFUL AND ITCHY FOR HIM. HE PROBABLY CAUGHT IT FROM THE POLLUTED WATER. AND LOOK AT MY DAUGHTER'S HAIR. THE SCALP ALSO HAD THIS INFECTION AND HER HAIR DROPPED OFF JUST LIKE THAT. IT IS ALSO ITCHY. I THINK MY DAUGHTER PROBABLY CAUGHT IT FROM THE PALOH RIVER, WHERE WE FARM. SHE PLAYED AROUND IN THE WATER AND SOON AFTERWARDS THIS SKIN INFECTION APPEARED.'**

I AM FEEDING MY BABY CONDENSED MILK; MY HUSBAND'S FRIEND FROM THE KAYAN LONGHOUSE GAVE THIS TO US. IT IS THEIR LEFTOVER FOOD. THEY HAVE USED THE MILK A LITTLE BUT YOU STILL HAVE SOME LEFT IN THE CAN. SO HE GAVE HIS CAN TO US. POWDERED MILK – WE CAN NEVER AFFORD TO BUY THAT. WE HAVE GONE ON FOR TWO DAYS WITHOUT FOOD WHEN THE RICE IS FINISHED, THE CASSAVA TUBER IS [TOO] YOUNG AND WE COULD NOT MANAGE TO FIND ANY SAGO IN THE FOREST.'³²

WHAT HAPPENS WHEN TRIBAL PEOPLES ARE MOVED?

When independent, mobile tribal people are suddenly shifted to a sedentary existence, surrounded by non-indigenous food and cultures and, especially, when they are removed to alien land, the health of individuals and of communities suffers catastrophically. This change rarely, if ever, affords tribal people a high standard of living but, rather, takes them to the edges of non-indigenous society – to slums and roadside squatter camps, underemployment, destitution or dependence. The shift towards higher-density living among mixed communities, often with domestic animals and usually in conditions of low sanitation, leads to diseases such as tuberculosis, intestinal parasites and cholera.³³

Sedentarisation causes a decrease in health in several direct ways: sanitation problems; contact with diseases from domestic animals; skin problems from clothing; ‘crowd’ diseases and epidemics such as measles, cholera and influenza; decreasing quality of diet; access to

alcohol and other drugs; and a decline in social bonds and sharing.³⁴ The shift away from tribal cultures and livelihoods can lead to chronic illnesses, including cancers, diabetes and heart disease, and social problems such as drug abuse, depression and violence. Divorced from their traditions and cultural coping mechanisms, individuals – especially the youth – can be led further away from their cultures and towards dependence on the non-indigenous society and the state. The power of Western medicine to conquer new diseases can often turn people away from their traditional cures and healers, thus undermining confidence in both leaders and their belief systems, leading to increased social decay. But the medical care available to indigenous communities tends to be of poor quality and low availability and is utterly insufficient compensation for the exposure to new illnesses. This report explores problems such as these that forced ‘progress’ brings to tribal communities.

‘Almost all observers throughout the world agree that the burden of infectious disease on hunting and gathering populations has increased since contact with settlements and is substantially increased by resettlement.’

Cohen 1989:99

‘Relocation has been a major contributing factor in declining [Aboriginal] health, reduced economic opportunities, increased dependence on the government and cultural disintegration.’

Royal Commission on
Aboriginal Peoples Canada, 1996

A makeshift Guarani camp, Brazil.



Chapter 2: Long-term impacts of settlement on health



SHORT AND LONG-TERM PROBLEMS

The diseases of first contact have caused the deaths of millions of indigenous people; since Columbus arrived in the Americas, an estimated 90% of the indigenous population has perished.²

Once the initial impacts of contact have passed through a population, longer-term problems frequently follow. Changes to diet, housing, livelihood, culture and a shift from nomadic to settled life lead to profound changes in health and well-being. Simultaneously, settled tribal peoples from Australia to the Arctic are exposed to ‘diseases of affluence’, such as obesity, high-blood pressure and diabetes, and also to ‘diseases of poverty’ caused by living in cramped conditions with poor sanitation. In common with many poor rural people who have to move to urban areas, many tribal people have to contend with living in slum conditions, doing hard physical labour and having to subsist on whatever foods they can glean

in the urban outskirts.³ The benefits of Western medicine and of ‘development’ are often unavailable and unaffordable.

LIFE EXPECTANCIES OF ABORIGINAL PEOPLES IN RICH COUNTRIES

In Canada, the USA, Australia and New Zealand, indigenous communities who have had long-term exposure to ‘western’ society have starkly worse health than their non-indigenous neighbours. They have considerably shorter life expectancies and higher rates of specific illnesses including diabetes and tuberculosis (TB). The vast majority of the indigenous people in these rich nations suffer extreme poverty, which causes severe health problems.⁴ Only a small minority follow their traditional diets and lifestyles.

‘Out here, we live on bush tucker. Old fellows and kids still hunt. We don’t have white tucker... In the big communities the young fellows get on the grog all the time. Here we stop ’em. We stay on the land of our grandfathers, always.’

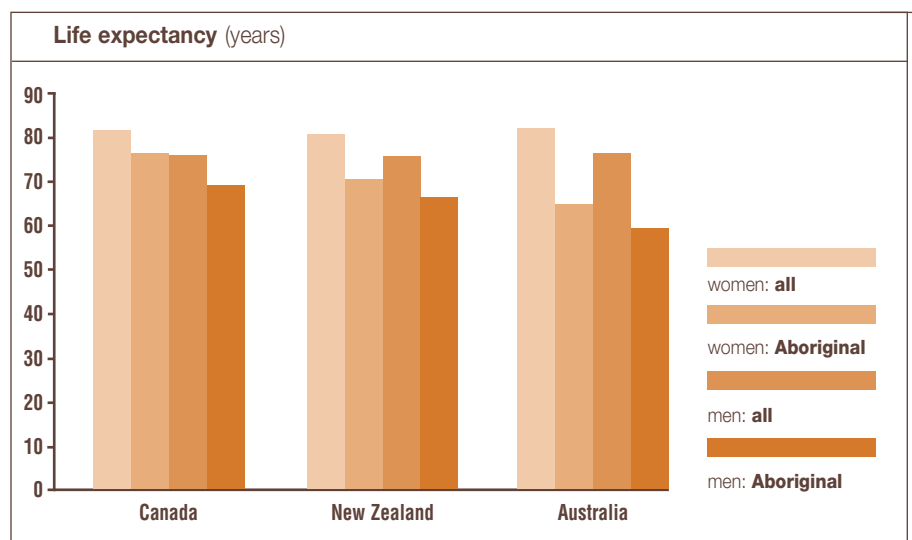
Lennie Jones and Albert Bailey, Senior Elders, Utopia, Australia, 2006¹

‘For most indigenous minorities, the transition to modernisation is a synonym for impoverishment, racism, violence, alcoholism, drug addiction, suicide and social disintegration.’

Froment 2001:258

‘There is a strong consensus among anthropologists who work among recently settled hunter-gatherers that the shift from a nomadic to a sedentary lifestyle generally compromises health and well-being.’

Dounias et al 2004:16



CANADA AND THE USA

In Canada, First Nations men and women have a life expectancy of 7.4 and 5.2 years less than the respective all-Canada statistics.⁶ On average, Native Americans have a life expectancy nearly six years less than other citizens of the USA. They are '770 percent more likely to die from alcoholism, 650 percent more likely to die from tuberculosis, 420 percent more likely to die from diabetes, 280 percent more likely to die from accidents [frequently alcohol related], and 52 percent more likely to die from pneumonia or influenza than the rest of the United States' (US Commission on Civil Rights 2004:8).

NEW ZEALAND AND AUSTRALIA

In New Zealand, Maori men live an average of 9 years and Maori women

an average of 10 years less than their non-Maori neighbours, and the gap is increasing. The Maori receive less medical assistance, of a lower quality, and, while death rates from cancer have fallen for other New Zealanders, they have increased among the Maori population.⁷

Typically, across Australia, Aborigines have a life expectancy 15-20 years below that of non-indigenous Australians. There have been some health improvements for Aborigines in recent years, but there is still an alarming gap between the health statistics of Aborigines and of Australians of European descent. It is important to note, however, that although the life expectancy of all Australia's Aboriginal people is low, **Aborigines living on their homelands live on average 10 years longer than those living in centralised or resettled communities.**⁸ In the area known as

Utopia, north of Alice Springs, for example, where hunting and gathering are still commonly practiced and traditional remedies still used - in conjunction with a travelling doctor service – people are 40% less likely to die prematurely than other Aborigines in the Northern Territories. Alarming, however, the Australian government is keen to close small communities like this and remove inhabitants to larger townships.⁹

Aborigines have a life expectancy 15-20 years below that of non-indigenous Australians.

Compared to other Australians, Aborigines are 22 times more likely to die from diabetes.





‘The health of Aboriginal and Torres Strait Islander Australians is disastrously poor... the fundamental cause is disempowerment, due to various factors including continued dispossession from the land, cultural dislocation, poverty, poor education and unemployment.’

Royal Australasian College of Physicians, 1997

THE HEALTH OF AUSTRALIA'S ABORIGINES

AUSTRALIA RANKS THIRD IN THE WORLD ON THE HUMAN DEVELOPMENT INDEX, YET THE HEALTH STATISTICS OF THE COUNTRY'S ABORIGINAL POPULATION ARE APPALLING. IN COMPARISON WITH OTHER AUSTRALIANS, ABORIGINES ARE:

- **22 TIMES MORE LIKELY TO DIE FROM DIABETES**
- **8 TIMES MORE LIKELY TO DIE OF CORONARY HEART DISEASE**
- **8 TIMES MORE LIKELY TO DIE FROM LUNG DISEASE**
- **6 TIMES MORE LIKELY TO DIE FROM A STROKE**
- **6 TIMES MORE LIKELY TO DIE AS AN INFANT**
- **MORE THAN TWICE AS LIKELY TO DIE FROM SELF-HARM¹⁰**

IN ADDITION, THEY HAVE 23 TIMES THE AVERAGE DEATH RATE FROM KIDNEY INFECTIONS AND ARE 10 TIMES MORE LIKELY TO SUFFER BLINDNESS THAN THE GENERAL POPULATION.¹¹

ONE MAJOR FACTOR THAT EXPLAINS THESE DIFFERENCES IS POVERTY: AVERAGE INCOMES OF THE ABORIGINAL POPULATION ARE ONLY 62% OF THOSE OF THE NON-INDIGENOUS POPULATION.¹² ABORIGINES HAVE POOR HOUSING, POOR ACCESS TO RESOURCES – INCLUDING HEALTH RESOURCES – AND A LETHAL COMBINATION OF LOSS OF TRADITIONAL KNOWLEDGE COUPLED WITH A LACK OF EDUCATION. SUCH POVERTY LEADS TO AN EXPONENTIAL RISE IN HEALTH PROBLEMS.

HOWEVER, BEHIND THESE FACTORS LIES A MUCH MORE COMPLEX ISSUE: THE LOSS OF IDENTITY COMMON TO MANY INDIGENOUS PEOPLE LIVING IN AFFLUENT COUNTRIES. THEY SUFFER NOT ONLY THE LOSS OF THEIR LAND, WHICH IS BY FAR THE MOST IMPORTANT FACET OF THEIR IDENTITY, BUT ARE ALSO SURROUNDED BY A SOCIETY WHICH VIEWS THEM AS BACKWARD AND BELONGING TO THE PAST. IN THESE CIRCUMSTANCES, ABORIGINAL PEOPLE, ESPECIALLY THE YOUNG, OFTEN FIND THEMSELVES CAUGHT BETWEEN TWO WORLDS, AND ILL-EQUIPPED TO LIVE IN EITHER.

SO HOW CAN THESE PROBLEMS BE OVERCOME? IS IT SIMPLY A CASE OF NEEDING TO INVEST MORE MONEY IN ABORIGINAL HEALTHCARE? THERE IS INCREASING AWARENESS IN AUSTRALIA (AND BEYOND) THAT THIS IS NOT THE ANSWER AND THAT THERE IS A NEED FOR EXAMINING FOUR ESSENTIAL INTERRELATED FACTORS: SELF-DETERMINATION, EDUCATION, SOCIAL JUSTICE AND HEALTH PROVISION. POVERTY, DISEMPOWERMENT AND LOSS OF ANCESTRAL LAND LIE AT THE HEART OF THE PROBLEM AND MUST ALL BE TACKLED DIRECTLY BEFORE ABORIGINAL PEOPLES ACROSS AUSTRALIA CAN ENJOY GOOD HEALTH AND APPROPRIATE HEALTHCARE.

DISEASES OF ‘POVERTY’ AND ‘AFFLUENCE’

‘In Peru, the poorest of the poor, the people who do not even have identity documents, the most neglected and abandoned, are indigenous people.’

Wilfredo Ardito, 2006¹³

Relocated indigenous peoples are amongst the poorest of the poor and are often the most deprived group in the society they are moved into. In Guatemala, for example, 87% of indigenous people live below the poverty line and over 60% live below the line of extreme poverty.¹⁴ Such measures of poverty mean little where indigenous peoples have their own land and independence; here they are rich in social and natural resources. But where they have joined – voluntarily or through circumstances beyond their control – the mainstream economy, without access to resources or land, they suffer disproportionately from the many health problems associated with poverty, including TB, water-borne diarrhoeal diseases, malaria and pneumonia.

In addition to high levels of poverty, the indigenous populations of Canada, America, New Zealand and Australia have high rates of diseases mostly associated with rich people in wealthy countries, so-called ‘diseases of affluence’. These include obesity, diabetes, heart disease, certain cancers, high blood pressure, alcoholism and depression. The imposition of ‘Western’ society on tribal communities has passed on to them the worst impacts of this lifestyle, without necessarily bringing them any ‘affluence’. These non-infectious diseases emerge when lifestyles change to include the over-eating of rich, sugary foods, under-exercising and exposure to alcohol, tobacco and stress.¹⁵ In short, there are serious chronic health

problems caused by exactly the opposite of tribal living.

Health and living conditions

Like non-indigenous poor people worldwide, settled tribal communities suffer from poor standards of living and housing conditions. This is true even for those indigenous communities in the most affluent countries, such as Canada and Australia. Among Aboriginal communities in Australia’s Northern Territory, for example, only 13% of settled households surveyed had functioning water, waste, cooking and cleaning facilities.¹⁶ Only 7% of Aboriginal children have normal, healthy ears due to desperately high rates of ear infections, many of which go untreated.¹⁷ A particular problem is middle ear infection, which often goes on to rupture the eardrum, which can severely impair hearing. In some Aboriginal communities, 60% of children experience this problem, and 50% have hearing loss severe enough to require hearing aids.¹⁸ ‘This is a disease of poverty, we see it around the world in underdeveloped nations, and I think in Australia it’s a shameful indicator of current living conditions of Aboriginal children. Quite clearly, without a doubt, it’s linked with overcrowding’ (Dr Sophie Couzos, NACCHO).¹⁹ The disease was rare before colonisation and is clearly linked to the change in lifestyle and living conditions imposed upon Aborigines since that time.²⁰

Similar problems exist in the Arctic: ‘Instead of the sod and snow igloos, Eskimos now live in plywood shacks or government-built prefabricated homes heated by coal stoves where air is not properly humidified and the population is all the more susceptible to respiratory infections. This adds to the chronic problem of middle ear disease (*otitis media*) and deafness among Eskimos’ (Moran 1981).

Cancers

Many hunter-gatherer communities have low rates of numerous forms of cancer. For example, typical rates of breast cancer among hunter-gatherer women are one hundred times lower than among American women.²¹ A few specific cancers were particularly common among Inuit groups (including salivary gland tumours). The rates of these cancers have fallen with sedentarisation, while the rates of cervical and lung cancers have risen.²²

One factor explaining increasing cancer rates with sedentarisation is exposure to tobacco. For example, between 1950 and 1980, lung cancer increased by 550% among the Alaskan Inuit.²³ Across the Americas, there were dramatic rises in tobacco smoking through the 1900s. Among the Dene Indians, for example, tobacco smoking was unheard of until the 1930s, but by the 1980s, 34% of Dene 10-14 year olds and 63% of 15-19 year olds smoked.²⁴

Among settled, largely assimilated indigenous communities, survival rates from cancer are typically much lower than among non-indigenous people.²⁵ Only 46% of Native American women in Arizona and New Mexico survive more than five years after diagnosis with breast cancer, compared with 76% of white women.²⁶ These communities are exposed to the factors in Western society that cause higher rates of cancer, but do not have equal access to the medical care necessary to tackle the condition.

Only 7% of Aboriginal children have normal, healthy ears due to desperately high rates of ear infections, many of which go untreated.



PUNAN TUBU, INDONESIAN BORNEO

THE PUNAN OF THE TUBU WATERSHED IN BORNEO HAVE DIVIDED INTO TWO GROUPS. THOSE UPSTREAM ARE STILL HIGHLY DEPENDENT ON WILD FOODS AND ARE LARGELY INDEPENDENT OF THE GOVERNMENT AND THE WIDER MARKET ECONOMY. THOSE DOWNSTREAM WERE STRONGLY ENCOURAGED BY THE GOVERNMENT TO SETTLE NEAR THE CITY OF MALINAU AND ARE NO LONGER NOMADS, BUT DEPEND ON PADDY FARMING, LABOURING AND THE WIDER MARKETS OF THE CITY. WHILST ECONOMICALLY THOSE PUNAN LIVING ON THE CITY'S FRINGE ARE CLEARLY 'BETTER OFF', THEIR WELL-BEING – BOTH MENTAL AND PHYSICAL – IS NOT SUPERIOR TO THOSE LIVING IN THE HIGHLANDS.²⁷

PERMANENT SETTLEMENT HAS NOT BROUGHT GREAT ADVANCES IN HEALTH TO THE PUNAN; ON THE CONTRARY, THEY ARE NOW EXPOSED TO DISEASES FROM DOMESTIC ANIMALS, SKIN DISEASES FROM DIRTY CLOTHING AND THE SOCIAL AND HEALTH PROBLEMS ASSOCIATED WITH CROWDED URBAN LIFE. HIGH MOBILITY AND LOW POPULATION DENSITY PROTECTED THE PUNAN FROM DANGEROUS LEVELS OF PARASITES AND INFECTIOUS DISEASES SPREAD BY POOR SANITATION. BUT IN THE PERMANENT VILLAGES, HIGHER LEVELS OF PARASITIC INFECTION HAVE LED TO ANAEMIA AND GROWTH STUNTING IN THE CHILDREN. VIRAL AND BACTERIAL DISEASES OF POOR SANITATION ARE ALSO HIGH AS ARE INFECTIOUS 'CROWD DISEASES', SUCH AS MEASLES AND CHICKEN POX. MALARIA IS ALSO A SERIOUS PROBLEM IN THE PERMANENT SETTLEMENTS DUE TO THE CONSTANT PRESENCE OF HUMANS AND THE AVAILABILITY OF STANDING WATER.

THE MOVE TOWARDS SEDENTARISATION HAS ALSO AFFECTED THE DIET OF THE PUNAN. SOME URBAN PUNAN WOMEN HAVE BECOME OBESE, AND THE RATES OF 'DISEASES OF AFFLUENCE' ARE RISING AMONG THIS GROUP. THOSE PUNAN TUBU WHO ARE STILL RELIANT ON WILD FOOD HAVE A HEALTHIER DIET, WITH MORE DIVERSITY, HIGHER LEVELS OF FIBRE, MINERALS AND VITAMINS, AND LOWER LEVELS OF HIGHLY PROCESSED FOODS AND FAT, SALT AND SUGARS.²⁸

Diabetes

Prior to European contact, it is thought that Aboriginal Australians had no experience of type 2 diabetes.³¹ The first case was recorded in 1923 and now it is responsible for the deaths of 8% of Aborigines, compared with 2% of deaths of non-indigenous Australians.³² Among some Alaskan communities, half the adult population has the disease and rates are increasing. The disease is also increasing among children.³³ The Canadian government has described a 'rising epidemic' of type 2 diabetes among the First Nations communities there.³⁴ Indigenous sufferers are more likely to die from the disease: First Nations Canadian women are four times more likely to die of diabetes than their non-indigenous neighbours.

Across Canada, the prevalence of diabetes among First Nations peoples varies by language family, cultural group and degree of isolation.³⁵ The more isolated communities have lower levels of the disease. The two main factors that have caused the rise in diabetes are lower levels of exercise and changes to diet. For example, Arctic peoples' 'traditional livelihoods were physically very demanding, but now rates of exercise are low and rates of obesity high. Diabetes is a serious symptom of this situation.'³⁶ A third important causal factor is a low weight at birth. Children of Aboriginal

mothers are twice as likely to have a low birth-weight than other Australian children. Poor maternal diet, and smoking and drinking in pregnancy, are some of the factors that lead to low birth-weight.³⁷

One of the starkest examples of rising diabetes among tribal peoples comes from the Pima or Akimel O'odham Indians of Arizona. For over 2,000 years, they had developed a complex system of irrigated agriculture, but in the late 1800s white settlers diverted the stream that fed their irrigation system. Terrible poverty and starvation followed. Changes to their population density, society and environment prevented them from subsisting on wild gathered foods, as they had done in past times of famine. Efforts to reinstate their water supply failed and sent the Akimel O'odham into debt. Many were forced to depend on handouts from the government, which consisted of sugar, lard and flour.³⁸ Others subsisted on what they could glean from labouring for the farmers who had taken over their land and water resources. This sudden change to a very unhealthy diet, coupled with a more sedentary life, resulted in one of the highest rates of diabetes in the world: approximately 50% of Akimel O'odham Indians over 35 have type 2 diabetes.³⁹

PIMA INDIANS, ARIZONA

IN THE PIMA RESERVATION, MORE THAN HALF OF INDIANS OVER THE AGE OF 35 HAVE DIABETES; WHILE THOSE LIVING IN THE MOUNTAINS SUFFER FAR LESS FROM THIS CONDITION. THE INTERNATIONAL DIABETES FEDERATION PREDICTS THAT EXCESS WEIGHT AND DIABETES WILL LEAD TO 'EARLIER DEATHS AND DISABILITIES'. IF UNTREATED OR DETECTED LATE – AS IS COMMON WITH TRIBAL PEOPLES – DIABETES CAN LEAD TO BLINDNESS, KIDNEY FAILURE, STROKES, HEART DISEASE AND AMPUTATIONS. THE IMPACT ON FUTURE GENERATIONS WILL BE CATASTROPHIC.

'The rapid cultural transition over one to two generations of many indigenous communities to a Western diet and sedentary lifestyle has led to diabetes replacing infectious diseases as the number one threat to their survival.'

Prof Stewart Harris, Canada, 2006

'Without urgent action there certainly is a real risk of a major wipe-out of indigenous communities, if not total extinction, within this century [due to diabetes].'

Prof. Paul Zimmet, International Diabetes Institute, 2006²⁹

'The human costs of unrestrained development on our traditional territory, whether in the form of massive hydroelectric development or irresponsible forestry operations, are no surprise for us. Diabetes has followed the destruction of our traditional way of life and the imposition of a welfare economy. Now we see that one in seven pregnant Cree women is sick with this disease, and our children are being born high risk or actually sick.'

Matthew Coon-Come, James Bay Cree, Canada, 2002³⁰

TRADITIONAL LIVES AND NUTRITION

One important factor that explains the massive increase in health problems among settled tribal peoples is nutrition. Typical hunter-gatherer diets are high in protein, fibre, vitamins and minerals and low in sugar, salt and saturated fats – the kind of diet that doctors advise we all follow. Hunting peoples typically eat a variety of lean, wild meats, which are much healthier than shop-bought meat products, which tend to be fatty and less rich in vitamins and minerals.

Tribal peoples' detailed knowledge about animals and plants is vital for their health. The Yanomami, for example, use 500 species of plant for food, medicine, and for building, hunting and fishing materials. They use nine species just for poisoning the fish that they catch.⁴⁰ The Tukano of the Colombia-Brazil border area have traditionally cultivated over

50 varieties of manioc. However, this knowledge is rapidly lost when people lose their land and independence. The Krahô of Brazil once cultivated many varieties of maize, but agricultural 'assistance' from missionaries and government agencies led to little improvement and the complete loss of many of their varieties of maize, sweet potato and manioc. Not only did these changes decrease the variety in their diets, but the Indians also lost the culturally vital seasonal rituals connected to these plants.⁴¹

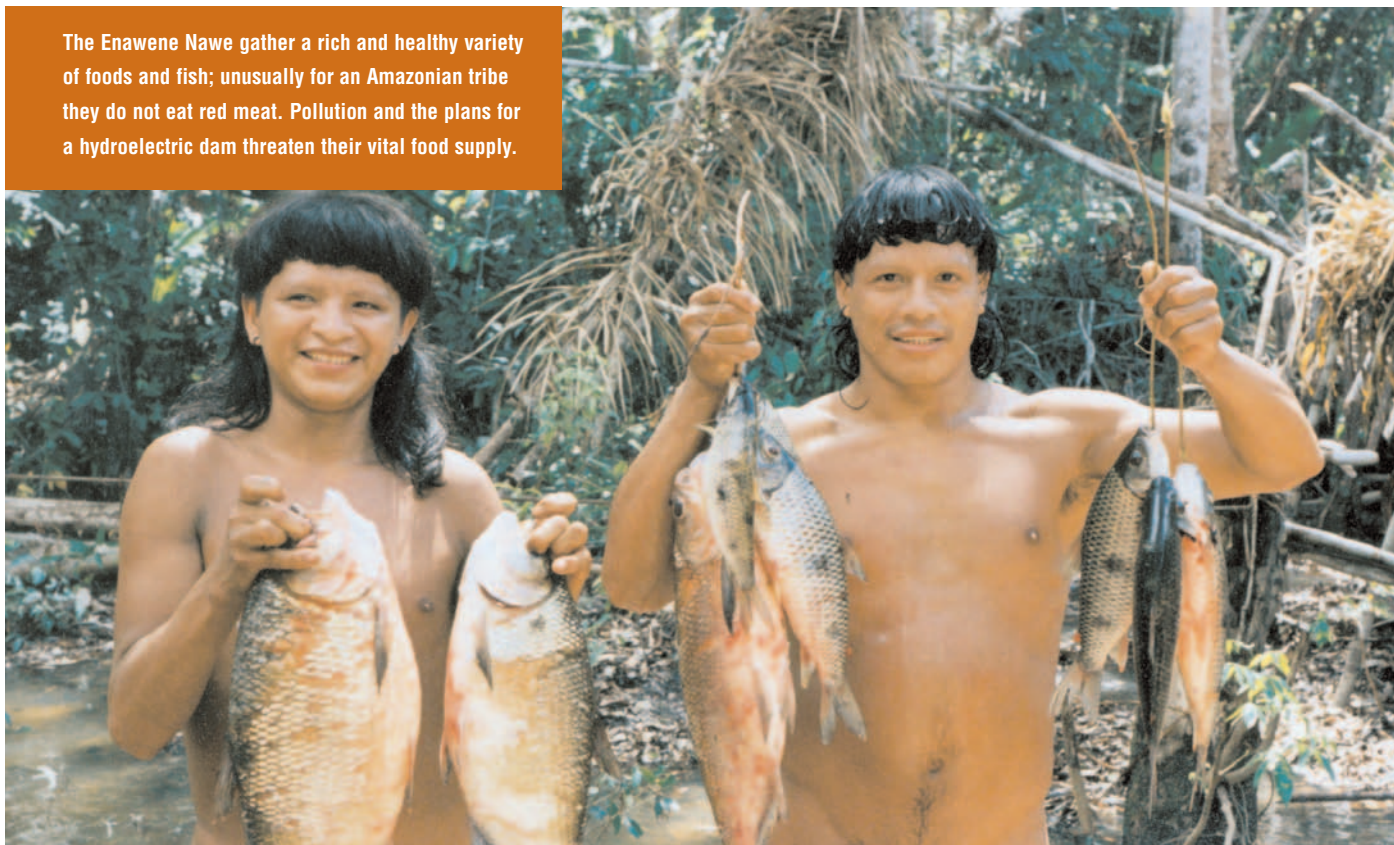
On their own land, tribal people have developed practices to counter potential nutritional deficiencies in their diets. For example, Hopi Indians added the ashes of green plants to their maize products, thus adding minerals including calcium and iron.⁴² Low levels of iodine in Papua New Guinea soils could lead to nutritional problems, but local people developed traditions of evaporating water from iodine-rich mineral springs. When the

government and missionaries started paying locals with shop-bought, low iodine, salt, these traditions were abandoned, iodine levels in the diet decreased and there was an 'explosive epidemic' of goitre and cretinism.⁴³

With time away from their land and traditions, indigenous people lose the detailed knowledge about the plants and animals on which they lived and the skills needed to gather, hunt and prepare them. In the Canadian Arctic, knowledge about traditional foods is still high, but is dwindling, especially among the younger generation who have been educated outside their communities.⁴⁴

The Yanomami use 500 species of plant for food, medicine, and for building, hunting and fishing materials.

The Enawene Nawe gather a rich and healthy variety of foods and fish; unusually for an Amazonian tribe they do not eat red meat. Pollution and the plans for a hydroelectric dam threaten their vital food supply.



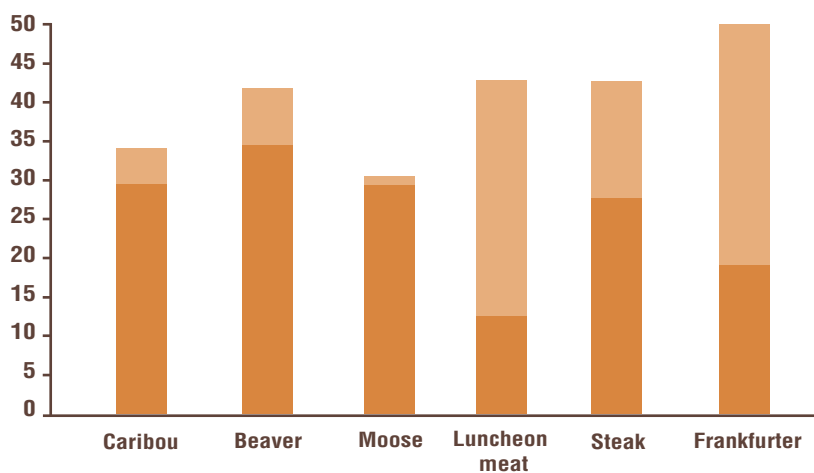
NUTRITIONAL CHANGE AMONG THE INNU, CANADA

UNTIL THE 1950s AND 1960s, THE INNU OF THE LABRADOR-QUEBEC PENINSULA IN EASTERN CANADA WERE NOMADIC CARIBOU HUNTERS, WHO TRAVELLED GREAT DISTANCES ACROSS THEIR SUB-ARCTIC TERRITORIES TO HUNT, FISH AND TRADE. THE CARIBOU PROVIDED MOST OF THEIR NEEDS – FROM THE SKINS FOR THEIR TENTS TO WEAPONS – BUT THE INNU ALSO HUNTED OTHER ANIMALS, INCLUDING BEAVER AND PORCUPINE, AND FISHED AND GATHERED BERRIES AND OTHER WILD FOODS. WHEN THE CANADIAN GOVERNMENT DECIDED TO SETTLE THE INNU IN FIXED VILLAGES, THEY SUFFERED HEAVILY. THEIR DIET OF WILD FOODS WAS LARGELY REPLACED BY SHOP-BOUGHT REFINED FOODS. IN THE PRE-SETTLEMENT DAYS, THE INNU WERE A HEALTHY AND VIBRANT PEOPLE, RENOWNED FOR THE STRENGTH OF BOTH MEN AND WOMEN. THEY WALKED UP TO 2,000 MILES A YEAR WITH HEAVY LOADS.⁴⁵ EVEN TODAY, LIFE IN THE COUNTRY IS VIGOROUS, REQUIRING HIGH LEVELS OF FITNESS TO DO ALL THE WALKING, CHOPPING, CARRYING AND LIFTING NEEDED TO SUSTAIN LIFE IN HUNTING CAMPS.

LIFE IN THE VILLAGES, HOWEVER, IS SEDENTARY, WITH MOST ADULTS TAKING VERY LITTLE EXERCISE. MANY HAVE A HIGH INTAKE OF CALORIES IN A DIET LARGELY MADE UP OF SATURATED FATS AND REFINED SUGARS AND STARCHES. THE LEVELS OF VITAMINS, MINERALS, PROTEIN AND OMEGA-3 FATTY ACIDS ARE CONSIDERABLY LOWER IN THE SHOP-BOUGHT FOODS EATEN IN THE VILLAGE THAN IN THE WILD FOODS EATEN IN THE COUNTRY. CARIBOU MEAT, FOR EXAMPLE, HAS OVER TWICE THE PROTEIN CONTENT OF TINNED LUNCHEON MEAT AND ONE TENTH OF THE AMOUNT OF SATURATED FAT. CARIBOU MEAT ALSO HAS THREE TIMES THE AMOUNT OF VITAMIN C AND NEARLY NINE TIMES THE AMOUNT OF IRON. BEAVER MEAT HAS 14 TIMES THE AMOUNT OF IRON. THE SHIFT TO EATING TINNED MEATS HAS CONTRIBUTED TO OBESITY, ANAEMIA AND A GENERAL DECREASE IN NUTRITIONAL QUALITY.⁴⁶

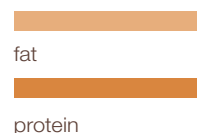


Protein and fat in traditional and shop-bought foods (grams per 100g)



'If I don't have caribou meat for a week, I feel sick. It sustains me for two or three days, but store bought food makes me hungry shortly after I have eaten it.'

Katnen Pastitshi, Sheshatshiu, 2006

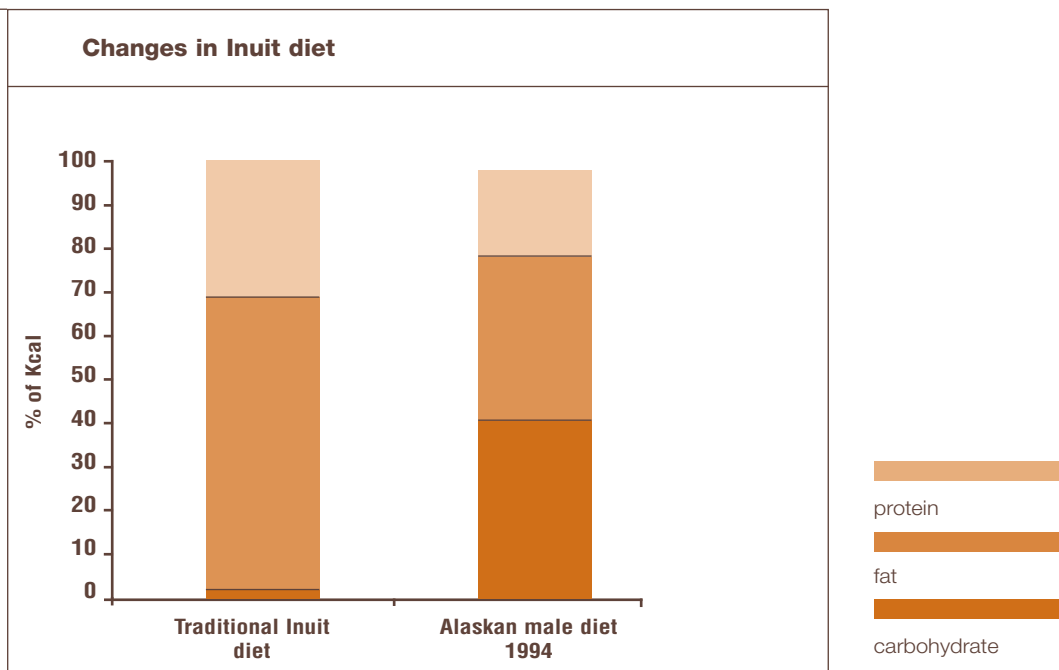


INUIT NUTRITION

THE TYPICAL TRADITIONAL INUIT DIET IS ABLE TO MEET ALL THE NEEDS OF PEOPLE EXPERIENCING EXTREME COLD AND HIGH LEVELS OF EXERCISE.⁴⁹ LEVELS OF VITAMINS, INCLUDING VITAMIN C, ARE HIGH IN THE TRADITIONAL DIET WHEN MEAT IS EATEN RAW, BLUBBER IS INCLUDED, AND LOCAL BERRIES AND SEA VEGETABLES ARE EATEN. INUIT COMMUNITIES HAVE BEEN REPORTED TO USE 129 SPECIES OF ANIMALS AND FISH AND 42 SPECIES OF PLANTS AS FOOD.⁵⁰ ALTHOUGH THE TRADITIONAL INUIT DIET OF MARINE ANIMALS AND FISH IS HIGH IN FAT, IT IS LOW IN SATURATED FATS AND THEREFORE DOES NOT CAUSE HIGH BLOOD CHOLESTEROL; INUIT PEOPLES TRADITIONALLY HAVE VERY LOW BLOOD CHOLESTEROL LEVELS AND, THEREFORE, LOW RATES OF CORONARY HEART PROBLEMS.⁵¹

ALTHOUGH THE CHANGE TO A WESTERN DIET HAS LED TO AN ACCELERATED GROWTH RATE AMONG INUIT CHILDREN, THE PRICE HAS BEEN AN INCREASE IN CANCERS AND DENTAL PROBLEMS. SUFFICIENT FRESH FRUIT AND VEGETABLES ARE HARD AND EXPENSIVE TO COME BY, SO WHEN INUIT PEOPLE CHANGE TO A 'WESTERN' DIET, THEIR INTAKE OF VITAMINS TENDS TO FALL.⁵² NO HIGH BLOOD PRESSURE WAS FOUND AMONG INUIT WOMEN IN THE 1950s, BUT FOLLOWING SEDENTARISATION THEY SHOWED LEVELS SIMILAR TO WESTERN WOMEN.⁵³ IN THE 1950s, INFANTS SUFFERED HEAVILY WITH THE CHANGES BROUGHT BY SEDENTARISATION. MOTHERS USED TO PRE-CHEW WILD FOODS FOR THEIR YOUNG CHILDREN, BUT THE AUTHORITY'S UNFOUNDED FEAR THAT THIS COULD SPREAD TB LED TO THE PRACTICE BEING DISCOURAGED, DESPITE A TOTAL LACK OF ADEQUATE ALTERNATIVE WEANING FOODS. INFANTS BEGAN TO BE BOTTLE-FED WITH WATERED-DOWN EVAPORATED MILK. THE NEGATIVE IMPACT ON THEIR HEALTH WAS SIGNIFICANT.⁵⁴ THE CHANGES IN DIET AMONG ARCTIC PEOPLES HAVE ALSO BEEN IMPLICATED IN THE RISING TIDE OF MENTAL HEALTH PROBLEMS EXPERIENCED THERE.⁵⁵

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'Arctic traditional food systems are most likely the best global examples of indigenous peoples' food being far superior to the modern food presented as alternatives.'⁹ Kuhnlein et al 2004:1451

The Kalahari Desert, like the Arctic, is an environment considered difficult for human survival. But the Bushmen, like the Inuit, have developed the knowledge and skills to live well off the land they call home. A study of Bushmen hunter-gatherers in the 1960s showed that their levels of iron and vitamin B12 were good and levels of anaemia were considerably lower than is average for tropical and sub-tropical populations.⁵⁶ Nutrition was good enough that, even among women who had been breast-feeding for two years or more, the levels of nutrients in the blood were high. In contrast, a study in 1984 that compared the nutrition and health of a similar but settled group of Bushmen, found that they were subsisting on a diet of maize porridge or beer, with sporadic intake of canned fruit, meat and vegetables. Most days, porridge or beer were the only foods. High rates of alcoholism and of drinking among young children were noted, whereas the community did not drink alcohol in the 1969 study.⁵⁷ In common with dispossessed Bushman communities across southern Africa, settlement has led to 'both dietary deficiency and poor health as a result of the residents' 'abandonment of traditional subsistence resources, reliance on alcohol, and general disruption of traditional life' (Kent and Dunn 1996:456).

In 2005, the UN Special Rapporteur on indigenous peoples visited South Africa. Regarding the Bushmen, he concluded: '[The] historic dispossession of land and natural resources has caused indigenous people to plunge from a situation of self-reliance into poverty and a dependency on external resources. Nutrition levels have dropped due to sedentarisation and lack of access to traditional bush food' (Stavenhagen 2005:10).

The International Labour Office (ILO) also conducted a survey of Bushman wellbeing in South Africa. They found that sedentarisation has caused a drop in nutrition, due to the replacement of fresh, wild foods with canned and processed foods; a lack of clean water, which has caused gastroenteritis in the Kalahari settlements; and a serious impact on mental health due to dispossession, frustration and substance abuse.⁵⁸ Gana and Gwi Bushmen, who were removed from their homes in the Central Kalahari Game Reserve in Botswana, were forbidden from hunting in 2002. There is little food available to gather around the resettlement camps, to which they were moved, so many Gana and Gwi are forced to rely on government rations, rather than their traditional foods.

BUSHMEN IN THE 1930s

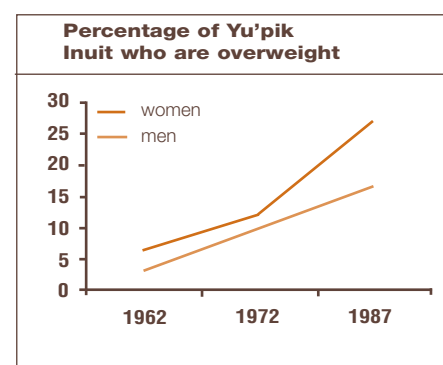
As non-Bushman peoples moved in to farm and ranch on Bushman territories, many Bushmen became serfs. The changes in their diet were recorded in the 1930s by the author Louis Maingard. He reports that, whenever possible, the Bushmen would return to their lands and to the livelihood of hunting and gathering. Their diet then consisted, as it had done traditionally, of a diverse collection of tubers, wild melons, grubs, fungi, bulbs, berries and the meat of a variety of wild animals. On the farms, however, the Bushmen serfs' diet 'consists chiefly of mealie-meal [cornmeal] and coffee, with separated milk, a little tea and sugar, and, occasionally, a little goat and sheep flesh. It is no more liberal in quantity than it is in quality... It is not surprising that malnutrition is rife among them' (Maingard 1937:235).

STARVATION AND OBESITY: TWO EXTREMES

Although there is evidence that Arctic communities have sometimes experienced seasonal malnutrition, there is a 'near absence of protein-calorie malnutrition among children of unacculturated traditional societies' (Wirsing 1985:309). But where tribal people have lost access to traditional foods and/or to the freedom to sustain themselves from their own land, malnutrition is a real problem.

In Guatemala, for example, indigenous children are twice as likely to be chronically malnourished and to have stunted growth as their non-indigenous neighbours.⁵⁹

Obesity is increasingly being recognised as a disease of poverty and, among indigenous peoples, a disease of increasing assimilation into non-indigenous cultures.⁶⁰ Indigenous people from places as diverse as Chile and the Canadian Arctic, are experiencing rapid increases in rates of obesity.⁶¹ Up to 30% of Inuit women are now clinically obese. Obesity has also been rising fast among the Yu'pik Inuit since the 1960s (see graph below).⁶²



SILENT GENOCIDE: **STARVATION AND THE GUARANI**

GUARANI COMMUNITIES IN BOTH ARGENTINA AND BRAZIL ARE EXPERIENCING RISING RATES OF MALNUTRITION, ESPECIALLY AMONG CHILDREN. IN 2005, 60% OF GUARANI MBYÁ CHILDREN IN THE IGUAÇÚ AREA OF ARGENTINA WERE MALNOURISHED.⁶³ IN THE FOLLOWING YEAR, 20 CHILDREN DIED FROM STARVATION IN JUST THREE MONTHS. THE GUARANI IN THAT AREA ARE LOSING THEIR LAND AT AN ALARMING RATE OF 10% A YEAR AND CANNOT GROW ENOUGH FOOD. 'THE INDIGENOUS DESTRUCTION HAS BEEN ACHIEVED IN A SYSTEMATIC MANNER BY BREAKING [THE GUARANI] WAY OF LIFE... WITHOUT THE FOREST, THERE'S NO POSSIBILITY FOR THE GUARANI WAY OF LIFE. IT IS AMAZING THAT THEY HAVE MANAGED TO RESIST EXTERMINATION THUS FAR' (CARLOS VICENTE OF THE NGO GRAIN 2005).⁶⁴

AS THEIR LAND IS PLUNDERED, THE GUARANI ARE FORCED TO LIVE IN DENSELY PACKED RESERVATIONS, CLOSE TO NON-INDIGENOUS COMMUNITIES. 'NOW WE EAT A LOT OF FAT AND SALT AND SWEET THINGS FROM THE WHITE WORLD, SO MANY GUARANIS ARE GETTING SICK' (ROSANDO MOREIRA, GUARANI ELDER, FORT MBORORE, 2005).⁶⁵

MALNUTRITION IS ALSO A PROBLEM IN THE NEIGHBORING BRAZILIAN STATE OF MATO GROSSO DO SUL, WHERE SIX GUARANI CHILDREN DIED IN ONE RESERVATION IN WHICH OVER 11,000 PEOPLE HAVE BEEN SQUEEZED INTO AN AREA INTENDED FOR 300. THE OFFICIAL RESPONSE TO THE MALNUTRITION PROBLEM INVOLVED HANDOUTS OF RICE, MANIOC MEAL, AND COOKING OIL. NOT ONLY ARE THESE FOODS POOR REPLACEMENTS FOR THEIR TRADITIONAL DIET, BUT MANY GUARANI ARE UNABLE TO FIND WOOD FOR FUEL AS THE FORESTS HAVE BEEN TORN DOWN. MATO GROSSO MEANS THICK FOREST, BUT THE FORESTS ARE BEING CLEARED FOR SOYA PLANTATIONS, CATTLE RANCHING AND SUGAR CANE AT THE EXPENSE OF BOTH THE ENVIRONMENT AND THE GUARANI COMMUNITIES WHO DEPEND ON THE FOREST FOR THEIR FOOD, RESOURCES AND CULTURE. UNABLE TO SUPPORT THEIR FAMILIES THROUGH TRADITIONAL, FOREST-BASED LIVELIHOODS, MEN ARE FORCED TO WORK ON SUGAR CANE PLANTATIONS IN DESPERATE CONDITIONS. IN THEIR BRIEF VISITS HOME, THEY BRING PROBLEMS INCLUDING SEXUALLY-TRANSMITTED DISEASES AND ALCOHOLISM, BUT LITTLE MONEY.

'AT THE ROOT OF THE SITUATION [OF CHILDREN STARVING] IS LACK OF LAND, WHICH IS THE CONSEQUENCE OF THE HISTORY OF THEFT AND DESTRUCTION OF OUR TRADITIONAL TERRITORIES, OF THE POLICY TO CONFINE US IN RESERVES, OF THE LOSS OF OUR LIBERTY AND EVEN THE LOSS OF WILL TO LIVE. WE WERE A FREE PEOPLE WHO LIVED SURROUNDED BY ABUNDANCE. TODAY WE LIVE DEPENDENT ON THE GOVERNMENT'S AID. IT IS LIKE HAVING A GUN COCKED AGAINST OUR HEADS... ALTHOUGH WE ARE WOUNDED, WE ARE NOT A DEFEATED PEOPLE AND WE HAVE EVERY FAITH IN OUR WISDOM' (STATEMENT BY LEADERS OF THE GUARANI-KAIOWÁ INDIGENOUS RIGHTS COMMISSION, APRIL 2005).

DENTAL HEALTH

One of the clearest signs of ‘Westernisation’ is an increased incidence in dental problems: Western societies are plagued by caries (cavities), gum disease and crowding of the teeth. Indigenous peoples eating traditional diets – with high fibre and low refined carbohydrates – typically have excellent teeth. In the 1930s, an American dentist, Weston A. Price, systematically studied the impact of an increasingly ‘Western’ diet on previously isolated peoples around the world. His study showed a clear pattern: isolated peoples had fine, strong teeth with almost no decay, but those who were no longer eating their traditional diets suffered heavily from dental problems. On average, susceptibility to caries increased 35 times on exposure to ‘Western’ diets.⁶⁶ Among a First Nations group on Vancouver Island in Canada, almost 50% of teeth were decayed, compared to a complete absence of caries among First Nations peoples who did not eat shop-bought foods.⁶⁷

Inuit communities traditionally ate low levels of carbohydrates, especially sugars, and benefited from high levels of fluoride in the meat of sea mammals. The combination of an increase in shop-bought, sugary foods and a decrease in the consumption of these traditional foods has led to catastrophic increases in tooth decay and periodontal disease.⁶⁸

Dental health problems can cause severe headaches and reduce people’s productive abilities. They are not only painful, but also affect nutrition, speech, social standing and self-esteem. Dental abscesses are sources of infections, which significantly increase children’s ill health. The introduction of sugars into an otherwise poor diet, combined with a lack of access to fluoride, dentistry and effective tooth-cleaning, is disastrous.⁶⁹

Indigenous peoples who are relocated from their land, or otherwise suddenly dislocated, do not jump into a world with all the benefits of ‘development’, even if they live in rich countries. Dental problems affect them more severely because they do not have access to the healthcare and dentistry of the rich. Expensive toothpastes, traditions of tooth-brushing, access to fluoridated water, regular dental check-ups and orthodontic treatment, all help to protect the rich from the impacts of their ‘modern’ diets. These resources are unavailable or unaffordable for relocated indigenous people who are suffering the effects of sudden dietary change coupled with a sudden loss of self-sufficiency and a newfound dependence on governmental assistance.

Recent years have seen two new threats to tribal people who are dependent on

their traditional foods. The first is contamination by chemicals from external sources of pollution. Examples include the high levels of PCBs and heavy metals in the meat of marine species used as food in the Arctic.⁷⁰ Amazonian peoples, such as the Enawene Nawe, Ikpeng and Mehinako, also report the contamination of the fish they eat by the agrochemicals from neighbouring soya plantations and cattle ranches. In Loreto, Peru, oil extraction has led to the contamination of water, fish and plants with heavy metals, such as lead and cadmium, with high levels being detected in the blood of indigenous children.⁷¹

The second is global warming, which is affecting Arctic peoples’ ability to access the animals on which they have long depended.⁷² ‘To Arctic indigenous peoples, climate change is a cultural issue. We have survived in a harsh environment for thousands of years by listening to its cadence and adjusting to its rhythms. We are part of the environment and if, as a result of global climate change, the species of animals upon which we depend are greatly reduced in number or location or even disappear, we, as peoples would also become endangered as well’ (Statement by six Arctic indigenous peoples’ organisations).⁷³



Chapter 3:

Identity, Freedom and Mental Health



A SENSE OF IDENTITY

The effects of relocation can affect all aspects of daily life for tribal people: active, important hunters become dependent and sedentary; children can no longer participate in cultural activities because they must follow alien school calendars and elders are replaced by non-tribal officials as the law-makers. Such changes can be devastating to whole communities. How severe this is depends on whether the community has been able to retain any control over its land and future, and on the rapidity of change; often in one generation, whole lives are turned upside down.

Trauma and dislocation are known to cause mental health problems to all people. Many indigenous communities have suffered intensely traumatic experiences, combined with a separation from their lands and loved ones. Genocide, epidemics of disease and repression leave survivors with deep mental scars. As indigenous communities break down under the strains of dislocation and resettlement, death rates from disease, suicide and violence soar. In Australia, trauma and grief have become 'central experiences of Aboriginal life' (Cohen 1999:19).

Externally-imposed changes lead to internal problems when indigenous communities self-destruct under the pressure. High levels of violence, drug and alcohol abuse, domestic violence and sexual abuse have been reported in many dislocated communities

in North America and Australia: evidence of terrible, deep-rooted damage.²

'Violence against the child, child abuse and exploitation contribute to, and are evidence of, the severe social strain under which many indigenous communities live. This strain is often a direct consequence of environmental degradation, displacement, the loss of traditional livelihoods and, in some cases, active attempts by authorities to homogenize and assimilate indigenous cultures' (Unicef 2003:11).

DEPRESSION AMONG TRIBAL ELDERS

One key factor in the social collapse that often occurs is that many parents and elders – once role models and successful individuals in their cultures – become helpless and lost when removed from their land, lowering their ability to provide for the young. Many succumb to depression and become increasingly unable to help or relate to their children as they grow up: 'We were ashamed of ourselves... Our sons were ashamed of us. We had no self-respect and nothing to give our sons except violence and alcoholism... Our children are stuck somewhere between a past they don't understand and a future that won't accept them and offers them nothing' (Boniface Alimankinni, Tiwi Islands, 2006).³

'The Guarani are committing suicide because we have no land. We don't have space any more. In the old days, we were free, now we are no longer free. So our young people look around them and think there is nothing left and wonder how they can live. They sit down and think, they forget, they lose themselves and then commit suicide.'

Rosalino Ortiz, Guarani Ñandeva, 1996¹

'Indigenous peoples often have higher rates of mental illness manifesting as alcoholism, substance abuse, depression and suicide... These problems come in the wake of social disintegration caused by modernization and the destruction of traditional authority structures and autonomous decision-making.'

Global Health Watch, 2005

SAYISI DENE, MANITOBA, CANADA

IN 1956, THE CANADIAN GOVERNMENT DECIDED TO REMOVE THE SAYISI DENE FIRST NATION FROM THEIR LAND, WITH NO WARNING OR CONSULTATION. THIS HITHERTO STRONG AND INDEPENDENT COMMUNITY WAS LEFT DEPENDENT ON CHARITY, HAND-OUTS AND SCAVENGING FROM THE RUBBISH DUMPS AROUND THE TOWN OF CHURCHILL.

THEIR HUNTING DOGS WERE SHOT, THEIR HUNTING METHODS BANNED AND THEY WERE FORCIBLY SETTLED IN BLEAK, ALIEN HOUSING. IN 1960, THE SALE OF ALCOHOL TO INDIANS WAS LEGALISED AND CONDITIONS FOR THE SAYISI DENE DETRIORATED. WITH NO WAY OF USING THEIR TRADITIONAL SKILLS, WITH NO EMPLOYMENT AND FORCED DEPENDENCE, THE OLDER GENERATION BECAME FIRST DEPRESSED AND THEN ALCOHOLIC. CHILDREN WERE TAUNTED AND ABUSED AT SCHOOL AS MEMBERS OF AN INCREASINGLY DESPISED COMMUNITY, AND RECEIVED LITTLE CARE OR GUIDANCE AT HOME, SO REGULARLY GOT INTO TROUBLE WITH THE LAW. OFTEN IT WAS THE CHILDREN WHO WOULD PROVIDE FOR THEIR PARENTS, FROM THE GARBAGE DUMP OR FROM STOLEN GOODS. THE IMPACT OF THIS ON THE PARENTS' SELF-RESPECT AND SELF-WORTH WAS DEVASTATING:

'[ON RETURNING FROM THE DUMP] MY DAD WAS STANDING BY THE WINDOW. I SAW THAT HE WAS CRYING. "I WAS A PROUD MAN," HE SAID. "I HUNTED, AND TRAPPED FOR MY FAMILY. I WAS SO PROUD, I NEVER WORE CLOTHES THAT WERE EVEN A LITTLE DAMAGED. BUT TODAY MY LITTLE GIRL BRINGS HOME FOOD FROM THE GARBAGE DUMP SO I CAN EAT"'ILA BUSSIDOR, 1997.⁴

SUICIDE OF NUKAK LEADER, MAO-BE

IN 2006, THE NUKAK LEADER, MAO-BE, TOOK HIS OWN LIFE BY DRINKING THE POISON HIS PEOPLE TRADITIONALLY USED FOR FISHING. HE HAD PLAYED A KEY ROLE IN TRYING TO HELP THE NUKAK RETURN TO THEIR HOME IN THE RAINFOREST AFTER THEY WERE FORCED TO FLEE WHEN COLOMBIA'S DRUGS WAR BURST INTO THEIR WORLD.

THE NUKAK HAD THEIR FIRST SUSTAINED CONTACT WITH OUTSIDERS IN 1988, AND SINCE THEN, OVER HALF THE TRIBE HAVE DIED, MOSTLY FROM MALARIA AND FLU. MAO-BE'S SUICIDE FOLLOWED THE TRAGIC DEATH OF A NINE YEAR OLD BOY AND A FLU EPIDEMIC, IN WHICH ALMOST A QUARTER OF THE DISPLACED TRIBE WERE TAKEN ILL, AFTER THEY HAD BEEN MOVED BY THE COLOMBIAN GOVERNMENT TO A CAMP JUST 2% THE SIZE OF THEIR OWN TERRITORY. GIVEN THAT THE NUKAK TRADITIONALLY LIVE IN SMALL NOMADIC FAMILY GROUPS, SUCH EPIDEMICS IN THEIR NEW SITUATION ARE NOT SURPRISING.

NOW LIVING ON THE OUTSKIRTS OF A TOWN AND DESPERATE TO RETURN HOME, THE NUKAK'S WILD FOOD IS IN SHORT SUPPLY AND THEIR HEALTH CONTINUES TO DECLINE.

Young Nukak woman, Colombia



SUICIDE AMONG TRIBAL CHILDREN AND YOUTH

Suicides among tribal elders are rare, however, compared with rates among the younger generation, especially young men.⁵ There are shockingly high rates of suicide among young tribal people from all corners of the world. Tiwi Islanders in Australia, Guarani children in Brazil, Innu and Inuit children in Northern Canada and Greenland and young Khanty herders from Siberia are among those with the highest rates of suicide.⁶ A startling example is the case of the 1,800 people who live in the capital of the Tiwi Islands, among whom one in four have attempted suicide.⁷ Across Australia, suicide rates are far higher among the Aborigine communities than among their neighbours (see graph).⁸ Over 300 Guarani Kaiowá committed suicide between 1985 and 2000, many of whom were young

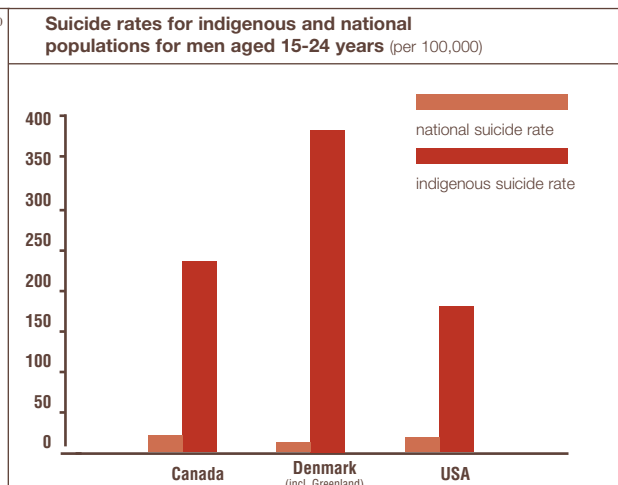
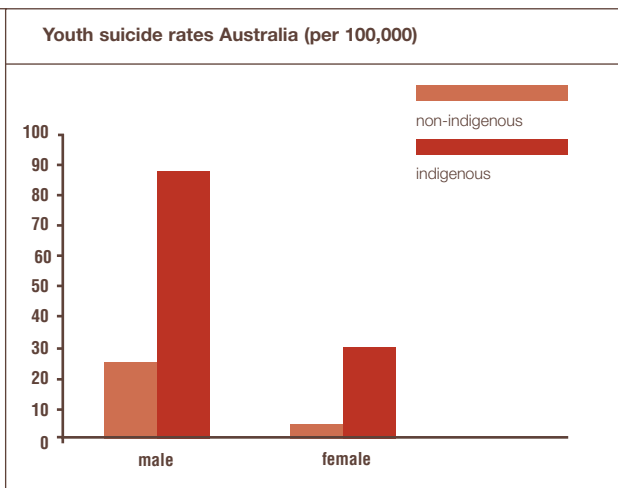
children. This represents one percent of the group’s population.⁹ A rate of over 180 per 100,000 for the whole Innu nation has recently been reported, compared with 12 per 100,000 across Canada (Samson in press).

Many Arctic indigenous people have high suicide rates. Suicide death rates in young indigenous men aged 15 to 24 are between 180 per 100,000 in Alaska and 396 per 100,000 in Greenland (see graph)¹⁰. Suicides were not unheard of in Arctic communities prior to sedentarisation; elderly or infirm members of the community would occasionally take their own lives in times of food shortage. However, suicide among young, healthy, productive individuals was unheard of. Among today’s Inuit peoples, suicide is most common among young men.¹¹

The contrast in suicide rates between indigenous youth and their non-indigenous

neighbours is often striking: in the Sioux Lookout Zone in Ontario, for example, young Indian males are over 50 times more likely to commit suicide than non-indigenous Canadians of the same age group.¹² A study in the 1970s reported an attempted suicide rate of 1,450 per 100,000 per year in one Alaskan town; this was ten times the rate for Los Angeles.¹³

What factors are driving so many young people to suicide? Are there any common factors across these different communities? A Unicef report associated suicides among indigenous children with social breakdown, low self-esteem, depression, racism, loss of land, integration problems and lack of opportunity. A major factor is the psychological trauma of dispossession and the sense of loss, dislocation and confusion that accompanies separation from land and traditional livelihoods.¹⁴



Between 1985 and 2000, over 300 Guarani-Kaiowá committed suicide. The youngest was Luciane Ortiz, she was nine years old.

'Many young men and women are taking their own lives because they don't have anywhere to live, to hunt, to practise our culture, to sing.' Marcos Veron, Guarani Indian leader¹⁵

NOTHING TO LIVE FOR: SUICIDE AMONG THE GUARANI

THE GUARANI KAIOWÁ COMMUNITIES OF THE BRAZILIAN STATE OF MATO GROSSO DO SUL, WHO TRADITIONALLY LIVED BY HUNTING, GATHERING AND SUBSISTENCE FARMING, HAVE BEEN DEVASTATED BY WAVES OF OUTSIDERS TAKING THEIR LAND FOR FARMING AND RANCHING. TO THE GUARANI, THEIR LAND IS THE ORIGIN AND SOURCE OF LIFE. IT IS WHERE THEY ARE FROM AND WHERE THEIR SOULS CAN FINALLY FIND REST. AS MARTA VICTOR GUARANI HAS SAID, 'WE INDIANS ARE LIKE PLANTS: HOW CAN WE LIVE WITHOUT OUR SOIL, WITHOUT OUR LAND?'

MISSIONARIES AND GOVERNMENT AGENTS HAVE CHANGED THE SOCIAL STRUCTURES, DECREASING COMMUNITIES' STRENGTH AND UNITY. COMMUNITY COHESION HAS BEEN FURTHER FRAGMENTED BY THE LOSS OF MANY MEN FORCED TO SEEK WORK IN DISTANT PLANTATIONS, DISTILLERIES AND TOWNS. THE SITUATION HAS BEEN WORSENERD BY ABJECT POVERTY AND THE CORROSIVE IMPACT OF SETTLERS IN THEIR AREA.

THE RESULT HAS BEEN A DRAMATIC RISE IN SUICIDES, ESPECIALLY AMONG YOUNG PEOPLE: 320 GUARANI-KAIOWÁ COMMITTED SUICIDE BETWEEN 1986 AND 2000, THE YOUNGEST WAS LUCIANE ORTIZ, AGED NINE. ONE COMMUNITY, CERRO MARANGATU, HAD A SUICIDE RATE OF 304 PER 100,000 RESIDENTS IN 2000, COMPARED WITH THE BRAZILIAN AVERAGE OF 4.8. ACROSS MATO GROSSO DO SUL, 11% OF DEATHS WERE DUE TO SUICIDE IN 2002 AND 2003. ONE OF THE MAIN RESERVATIONS, DOURADOS, IS FAR FROM THE GUARANI'S OWN LAND AND IS VERY CLOSE TO THE SECOND LARGEST CITY IN MATO GROSSO DO SUL. HERE, THERE HAVE BEEN THE MOST SUICIDES.¹⁶

'SUICIDES OCCUR AMONG YOUNG PEOPLE BECAUSE THEY ARE NOSTALGIC FOR THE PAST. YOUNG PEOPLE ARE NOSTALGIC FOR THE BEAUTIFUL FORESTS, THEY WANT TO EAT FRUITS FROM THE FOREST, THEY WANT TO GO OUT AND FIND HONEY, THEY WANT TO USE NATURAL REMEDIES FROM THE FOREST. IN DOURADOS... A YOUNG PERSON TOLD ME HE DIDN'T WANT TO LIVE ANYMORE BECAUSE THERE WAS NO REASON TO CARRY ON LIVING – THERE IS NO HUNTING, NO FISHING, AND THE WATER IS POLLUTED' (AMILTON LOPES 1996).¹⁷

THE GOVERNMENT ESTABLISHED RESERVES LIKE DOURADOS IN ORDER TO FREE UP THE GUARANI'S ORIGINAL TERRITORY FOR AGRICULTURE AND RANCHING. THE GUARANI WERE EXPELLED FROM THEIR SACRED TEKOHAS (PLACES OF BEING) AND ONLY GIVEN THE OPTION OF MOVING TO THESE OVER-POPULATED AREAS. 'THE YEARS WITH THE HIGHEST INCIDENTS OF SUICIDE WERE 1990, 1995, 1997 AND 1998. IT'S PRECISELY IN THESE YEARS THAT THE INDIGENOUS COMMUNITIES LIVED THROUGH A SITUATION OF GREATLY INCREASING HUNGER, POVERTY, CONFLICTS AND HOPELESSNESS. SUICIDES STOP AS SOON AS THE GUARANI AND KAIOWÁ REACT AND SEEK TO OVERCOME THE SITUATION BY TAKING BACK OR REOCCUPYING THEIR TRADITIONAL TERRITORIES, WHICH ALLOW THEM TO BE AND LIVE IN THEIR WAY' (CIMI 2001).¹⁸

'WHEN I WAS A CHILD LIFE WAS EASIER BECAUSE THERE WAS FOREST, ENOUGH FOOD AND WE MADE FARINHA [MANIOC FLOUR] AND FISHED. WE MADE OUR OWN SUGAR FROM THE FOREST BEES. I WAS BORN IN AMAMBAI AND IT WAS AN INDIGENOUS VILLAGE THEN. I THINK THINGS ARE MUCH WORSE NOW. WE ARE SURROUNDED BY RANCHERS HERE. THEY HAVE FENCED US IN AND THEY WON'T LET US IN TO HUNT ARMADILLOS AND PARTRIDGES. THEY WON'T EVEN LET US LOOK FOR MEDICINAL PLANTS ON THE FARMS. THE TIME WHEN WE USED TO GET HONEY FROM THE BEES IS OVER BECAUSE THERE IS NO FOREST LEFT. THERE IS NOTHING FOR THE INDIAN NOW. HE HAS TO LOOK FOR EVERYTHING IN THE TOWN NOW. SO THAT'S WHY THE YOUNG ARE COMMITTING SUICIDE BECAUSE THEY THINK THE FUTURE WILL BE WORSE' (ADOLFIN NELSON, LIMÃO VERDE, 1996).¹⁹

A bereaved Guarani mother and her children waiting beside a coffin. The wave of suicides that has struck the Guarani ~ Indians in the last 20 years is unequalled in South America.



‘SUICIDES OCCUR AMONG YOUNG PEOPLE BECAUSE THEY ARE NOSTALGIC FOR THE PAST. YOUNG PEOPLE ARE NOSTALGIC FOR THE BEAUTIFUL FORESTS, THEY WANT TO EAT FRUITS FROM THE FOREST, THEY WANT TO GO OUT AND FIND HONEY, THEY WANT TO USE NATURAL REMEDIES FROM THE FOREST.’

AMILTON LOPES, GUARANI, BRAZIL, 1996

THE STOLEN GENERATION IN AUSTRALIA

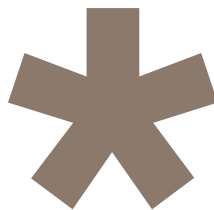
IN AUSTRALIA BETWEEN 1910 AND THE 1970s, CHILDREN WERE NOT ONLY SENT AWAY TO SCHOOL, BUT UP TO ONE IN THREE CHILDREN WERE REMOVED COMPLETELY FROM THEIR FAMILIES. THEY HAD **'THEIR IDENTITY AND FAMILY BACKGROUND HIDDEN FROM THEM, [WERE] KEPT IN INSTITUTIONS OR SENT FROM ONE FOSTER HOME TO ANOTHER, AND [SUFFERED] ONGOING ABUSE (EMOTIONAL, PHYSICAL AND SEXUAL)'** (MCKENDRICK 2001:69).

THE FAMILY IS THE MOST IMPORTANT UNIT IN ABORIGINAL SOCIETY; IT IS ESSENTIAL TO HEALTH – PHYSICAL, PSYCHOLOGICAL, SPIRITUAL AND CULTURAL. FAMILIES RETAIN A STRONG ATTACHMENT TO THEIR 'COUNTRY'. NOT ONLY DID THE CHILDREN OF THIS 'STOLEN GENERATION' LOSE THEIR FAMILY TIES AND THEIR CHILDHOODS, THEY LOST THEIR IDENTITY, CULTURE AND THEIR CULTURAL LINKS TO THEIR LAND. THIS HAS HAD DEVASTATING IMPACTS ON THEIR MENTAL WELLBEING: OVER HALF OF THE STOLEN GENERATION INTERVIEWEES IN ONE STUDY HAD ATTEMPTED SUICIDE.²⁷

CURRENTLY, IT IS THE JUDICIAL SYSTEM THAT TAKES ABORIGINAL YOUTH FROM THEIR FAMILIES: A DISPROPORTIONATE NUMBER OF YOUNG ABORIGINALS ARE IN JUVENILE DETENTION AND PRISONS. FOR EXAMPLE, A 15 YEAR-OLD BOY WHO STOLE A PACKET OF COLOURED PENS AND WAS SENT TO A YOUTH DETENTION CENTRE THOUSANDS OF KILOMETRES FROM HIS HOME, COMMITTED SUICIDE IN 2000.

Of course, these factors are cyclical and interconnected, so it can be hard to separate cause from effect. Parents have been driven to alcohol abuse and depression by the suicide of a child. Children abused in boarding school may grow up to abuse their own children. But underlying all these issues is the crucial factor of dislocation through separation from land and culture.

However, not all indigenous communities have such high rates of suicide. Among the Cree in Quebec, for example, rates are not high in relation to averages for the province.²⁸ Explanations for this can be found in community-level factors. In British Columbia, groups with strong links to their land and culture reported no suicides, while those with no continuity to their land and culture reported rates up to 10 times the national average.²⁹ Guarani communities in which suicide has been a terrible problem have reported no suicides since returning to their land to live in their traditional ways.³⁰



Chapter 4:


Maternal and Sexual Health

MATERNAL AND INFANT HEALTH IN TRADITIONAL TRIBAL SOCIETIES

All the factors discussed previously regarding displaced tribal communities compound to compromise women and children's health. Poor maternal diets, a lack of suitable weaning foods, exposure to alien infectious diseases, squalid living conditions in settlement camps, alcohol abuse and a loss of traditions of reciprocity and midwifery combine to endanger women and children in particular.

Tribal communities living on their own lands, with access to traditional medicines and healers, rich diets of wild foods and

strong support systems, would typically have infant mortality rates lower than comparable communities of rural poor people and lower than they would do if moved to unsanitary settlement camps. Moving communities nearer to clinics does not automatically improve child health, although infant mortality rates do drop in some places. Improvements in child survival can be effectively delivered via good vaccination programmes coupled with affordable, in situ primary healthcare that works in tandem with traditional health systems. This avoids the problems outlined above when communities are moved.



'[Our wives] are permanently exposed to death because of lack of care during their pregnancy and deliveries. This came with the so-called modern life into which we were dragged. It did not exist when we were living in our natural environment. We had so many plants for such problems...'

Twa 'Pygmy' man, Kalehe district, Kivu, Democratic Republic of Congo¹

MATERNAL AND CHILD HEALTH AMONG THE ENAWENE NAWE



THE ENAWENE NAWE PEOPLE OF MATO GROSSO STATE, BRAZIL, NUMBER JUST UNDER 400 LIVING IN TWELVE LONGHOUSES, WHICH ARE MOVED EVERY FEW YEARS. EVEN BEFORE FORMAL CONTACT THEY SUFFERED ILLNESSES FROM OUTSIDERS AND LOSS OF LIVES THROUGH KIDNAP AND VIOLENT RAIDS BY NON-INDIANS.

IN THE 1970S AND 1980S, PRESSURE FROM OUTSIDERS WANTING TO SETTLE IN ENAWENE NAWE LANDS LED TO EFFORTS TO LEGALLY DEMARCATÉ THE COMMUNITY'S TERRITORY.² AT THIS TIME THERE WAS A HIGH RATE OF INFANT DEATHS AMONG THE ENAWENE NAWE, WITH MANY CHILDREN DYING OF PNEUMONIA, A DISEASE THAT HAD INCREASED SINCE CONTACT WITH OUTSIDERS. THE COMMUNITY ASKED A LOCAL NGO, OPAN, TO HELP WITH A HEALTH PROGRAMME.

IN 1998, A ROAD WAS BUILT ILLEGALLY THROUGH ENAWENE NAWE LANDS, LEADING TO INCREASED CONTACT WITH OUTSIDERS AND THEIR ILLNESSES. AFTER THE ROAD WAS BUILT, A SERIES OF EPIDEMICS SWEEPED THROUGH THE VILLAGE. IN THE FIRST WEEKS, TWO YOUNG WOMEN DIED. OVER THE NEXT FEW MONTHS, MANY INFANTS AND CHILDREN DEVELOPED PNEUMONIA, BUT THE SCALE OF THE PROBLEM WAS LIMITED BY EFFECTIVE, LOCAL MEDICAL CARE PROVIDED BY OPAN. THE CHILDREN WERE GIVEN ANTIBIOTICS AND ONLY VERY FEW NEEDED TO BE EVACUATED.

TOGETHER, THE COMMUNITY AND OPAN SET UP A HEALTH EDUCATION PROJECT TO TRAIN LOCAL INDIGENOUS HEALTH WORKERS, WHICH WAS VERY SUCCESSFUL AND SUSTAINABLE. INFANT MORTALITY WAS HALVED AND, FIVE YEARS AFTER THE NON-INDIGENOUS NURSE LEFT, THE LOCAL HEALTH WORKERS ARE STILL WORKING FOR THEIR COMMUNITY.³

Similarly, removing mothers to hospitals at the time of childbirth can improve maternal survival rates, but this is not the only way. The most effective and appropriate approaches work with traditional birth attendants, training them in the safest methods of delivery and hygiene, and ensure that access to hospital care is available when needed – rather than as a matter of standard practice. For such programmes to work, frontline carers need to know when to seek external medical care, and good systems of communications and transport must be available to ensure that women in need are able to reach appropriate medical centres.⁴

A study in Cambodia asked indigenous women where they would prefer to give birth: 5% said the health centre; 94% preferred the village. The alien hospital culture clashes with the women's traditions. At the health centre, they have to give birth publicly on a ward, cannot practice certain rituals and cannot have family members present to support them.⁵ Isolated peoples are also likely to pick up alien diseases in distant health centres.

Amnesty International recently reported that pregnant indigenous women in Peru are avoiding necessary medical care due to the cultural insensitivity of the medical professionals. But by opting to give birth at home, some families are fined and many also fall victim to a discriminatory bureaucracy: children born at home are denied birth certificates, without which they cannot access free state health services.⁶

Since the 1970s, Canadian policy has been to remove Inuit women from their community for childbirth. Many women became so desperate to avoid being taken away for childbirth, that they

lied to medics about when their babies were due. Older women in the community felt that their knowledge had been 'discredited, wasted and ignored' and women suffered from the erosion of their self-sufficiency and confidence regarding birth, because the whole process was literally removed from the community. There was a loss of traditional ante-natal care, in which elder women monitored the mother, ensuring that she had a special diet and kept active, and eased the birth with herbal medicines and an ability to get the mother psychologically prepared and calm. In distant centres, the process of birth became a strange, alien, invisible process. The lifelong bond of 'kinship and mutual responsibility' between midwife and child was lost.⁷

BIRTH SPACING AND BREASTFEEDING

Both missionaries and government agencies have acted to change cultural practices that act in the interests of both mothers and their children. Tribal women of many cultures ensure long spaces between the births of their babies through a variety of methods including herbal contraceptives, abstinence and long periods of breastfeeding. Such well-spaced births are in the interests of both the child and their mother's health, especially among nomadic peoples. When external influences change these practices, births become closer together and, therefore, women have to wean their children earlier. Early weaning, especially when low-quality or unhygienic foods are used, can be very dangerous to child health. Aggressive marketing of formula milks can lead women to stop breast-feeding earlier and thus have children closer together. Where women have inadequate resources to buy sufficient milk powder and to mix it with clean, boiled water,

this leads to malnutrition and exposure to disease. In the Arctic, high levels of middle-ear infection (*otitis media*) have been associated with the switch from breastfeeding to the giving of cow's milk.⁸

SOCIAL CHANGE AND SEXUALLY TRANSMITTED INFECTIONS

'Because of our small numbers, our virtual invisibility, and the lack of public health outreach into our communities on almost any level, HIV has run rampant, and there is a real and immediate danger of a sweeping decimation of our people. Without clear information which is culturally sensitive, the combination of fear, ignorance and the resulting stigma threaten to just destroy our already physically fragile communities'

Native American Leadership

Commission on Health and AIDS, 1994

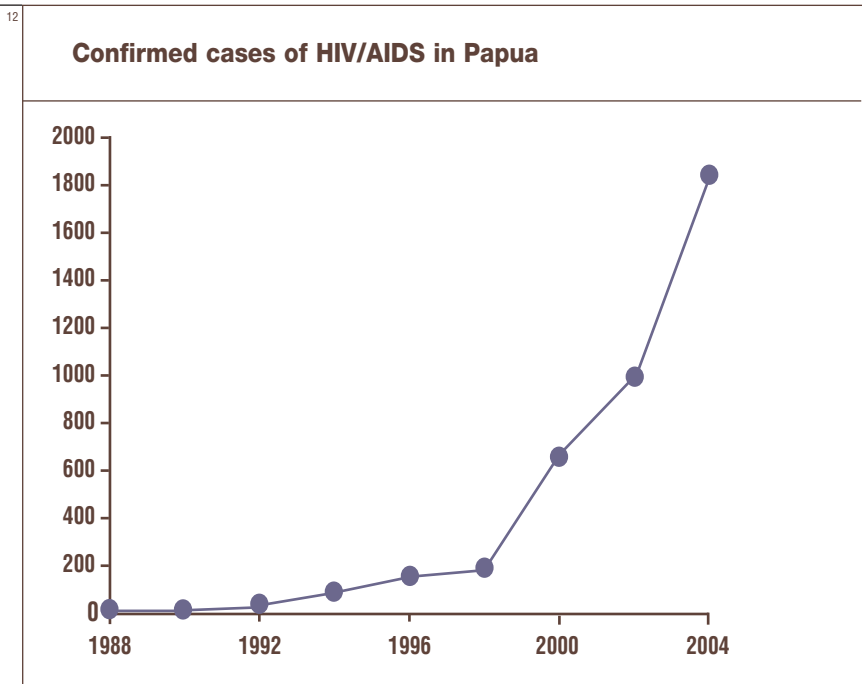
With dramatic cultural change and increased contact with outsiders to the community, indigenous and tribal groups are exposed to an increased risk of sexually transmitted infections (STIs). In Africa in particular, there has been a spread of STIs to indigenous groups with the arrival of large-scale development projects. For example the risk of HIV/AIDS to Ogoni women has increased with the arrival of oil workers.⁹

HIV/AIDS IN WEST PAPUA

THE 312 TRIBES OF WEST PAPUA HAVE SUFFERED EXTREME OPPRESSION AND VIOLENCE SINCE THE INDONESIAN OCCUPATION IN THE 1960s. SOME REMAIN ISOLATED FROM THE WIDER PAPUAN SOCIETY. HIGHLAND PEOPLES, SUCH AS THE AMUNGME, LIVE BY SHIFTING CULTIVATION, PIG-REARING, HUNTING AND GATHERING. LOWLAND PEOPLES, SUCH AS THE ASMAT, HUNT GAME AND COLLECT SAGO. THE INTRUSION OF THE INDONESIAN GOVERNMENT AND MIGRANTS INTO PAPUAN PEOPLES' LIVES HAS LED TO THE SPREAD OF DISEASE AND MALNUTRITION, CAUSING LOW LIFE EXPECTANCIES AND HIGH INFANT MORTALITY RATES.¹⁰

THE 'DEVELOPMENTS' OF MINING AND LOGGING HAVE BROUGHT ENVIRONMENTAL AND SOCIAL CATASTROPHES AND NOW AN ADDITIONAL DEADLY PROBLEM – HIV/AIDS. HALF OF THE TWO MILLION PEOPLE LIVING IN THE PROVINCE OF PAPUA ARE NOW OUTSIDERS, AND THE AREA NOW HAS THE HIGHEST RATE OF HIV/AIDS IN INDONESIA: EVEN THE MOST CONSERVATIVE ESTIMATES PUT THE FIGURE AT 15 TIMES THE NATIONAL RATE¹¹ (SEE GRAPH ¹²). KNOWN CASES OF THE DISEASE REPRESENT A SMALL FRACTION OF THE NUMBER OF PEOPLE INFECTED.¹³ IN 2004, THERE WERE AN ESTIMATED 15,000 PEOPLE WITH AIDS AND 60,000 PEOPLE INFECTED WITH HIV/AIDS IN PAPUA.¹⁴

MOST OF THE CASES CAN BE TRACED BACK TO THE COMMERCIAL SEX INDUSTRY, WHICH HAS ACCOMPANIED THE ARRIVAL OF MIGRANT WORKERS IN THE FISHING, LOGGING AND MINING SECTORS. A STUDY IN 2001 FOUND THAT OVER A QUARTER OF TESTED PROSTITUTES WERE HIV POSITIVE. OFFICIAL SOURCES BLAME VISITING THAI FISHERMEN AND THEIR BROTHELS, OR EVEN THE SUPPOSED 'SEXUAL DEVIANCY' OF THE PAPUAN TRIBES. PEOPLE WORKING WITH THE TRIBES HAVE NOTED THAT MIGRANTS HAVE BROUGHT THE DISEASE, THAT THE INDONESIAN GOVERNMENT HAS FAILED TO REACH PAPUANS WITH HIV/AIDS AWARENESS, TESTS OR TREATMENTS, AND THAT THE NEGATIVE STEREOTYPES OF PAPUANS HELD BY THE INDONESIAN PEOPLE AND GOVERNMENT ARE EXACERBATING THE PROBLEM. SOME BLAME THE MILITARY MORE DIRECTLY FOR BRINGING PROSTITUTES, WHO ARE KNOWN TO BE INFECTED WITH THE VIRUS, INTO TRIBAL AREAS.¹⁵

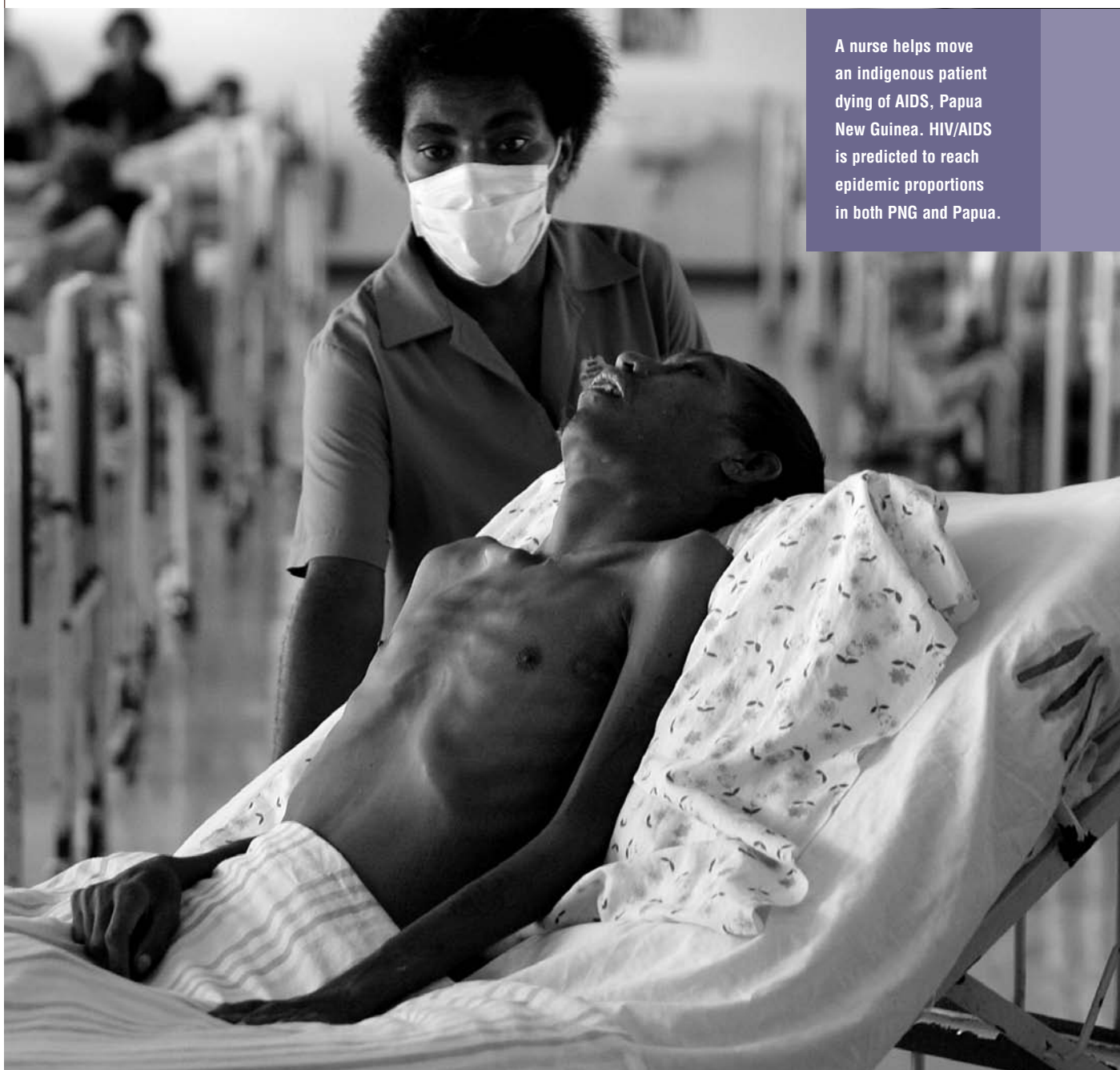


In 2004, there were an estimated 15,000 people with AIDS and 60,000 people infected with AIDS in Papua.

HIV/AIDS IN WEST PAPUA CONTINUED

'MANY PEOPLE BELIEVE THE MILITARY HAVE A VESTED INTEREST HERE IN INTRODUCING AND PERPETUATING THE [HIV/AIDS] PROBLEM. THE INTRODUCTION OF HIV/AIDS IS BEING UNDERTAKEN AS AN EFFECTIVE WAY OF WIPING OUT INDIGENOUS PEOPLE. ALARMING RATES OF HIV/AIDS AMONG REMOTE TRIBES IN THE MERAUKE REGION IS A CASE IN POINT. THIS HAS RESULTED FROM THE INTRODUCTION OF PROSTITUTION IN THE AREA AND THE DELIBERATE OFFERING OF FAVOURS TO LOCAL TRIBAL LEADERS IN RESPONSE TO THE ACQUISITION OF INDIGENOUS LAND FOR COMMERCIAL DEVELOPMENT. MANY BELIEVE THIS IS A BLATANT CASE OF ETHNIC CLEANSING' (REVEREND JOHN BARR OF THE UNITING CHURCH IN AUSTRALIA).¹⁶

IN ASSUE SUB-DISTRICT, SECURITY PERSONNEL HAVE BEEN ACCUSED OF SUPPLYING BOTH ALCOHOLIC SPIRITS AND SEX WORKERS TO TRIBAL LEADERS TO HELP THEM ACCESS THE PRIZED, FRAGRANT WOOD GAHARU (AGARWOOD), WHICH IS USED FOR INCENSE. THE AWYU AND WIYAGAR TRIBES IN THE AREA ARE IN DANGER OF COMPLETE EXTINCTION DUE TO THE SPREAD OF HIV/AIDS FROM THE PROSTITUTES.¹⁷

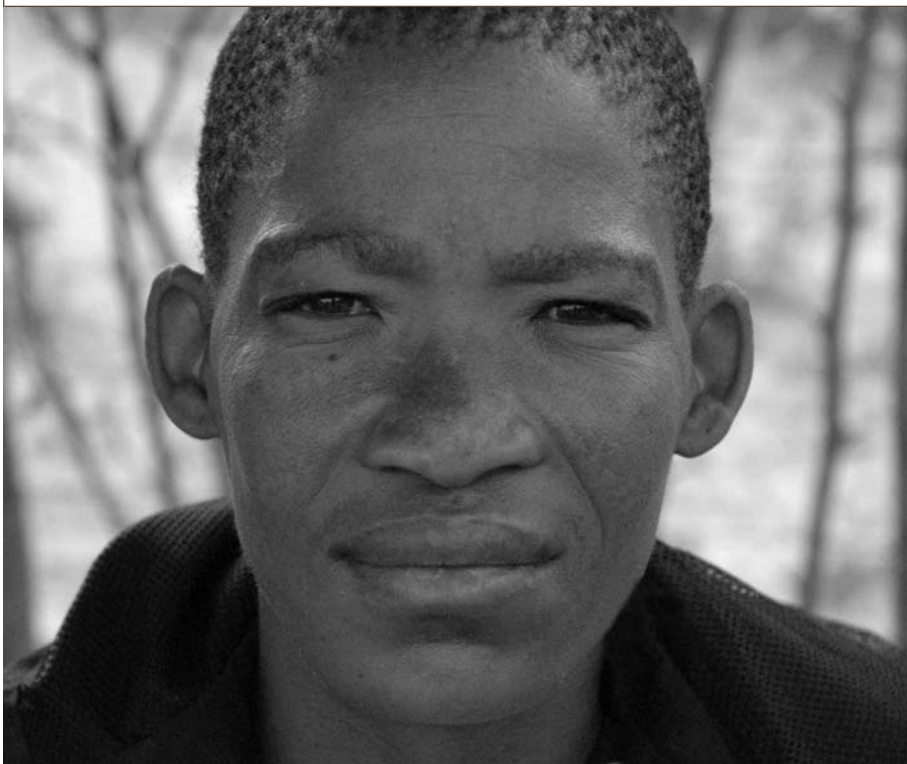


A nurse helps move an indigenous patient dying of AIDS, Papua New Guinea. HIV/AIDS is predicted to reach epidemic proportions in both PNG and Papua.

Statistics on STIs among displaced indigenous communities are hard to come by, especially as many governments do not want such figures to be known. Deaths from AIDS are often disguised, or under-reported – purposefully or otherwise – as deaths through TB, pneumonia or ‘other

causes’, leading to significant under-reporting. In the New Xade resettlement site in Botswana, for example, 40% of deaths of Gana and Gwi Bushmen in 2002 were recorded as AIDS deaths. It is likely that a further 10% of deaths in this camp were due to AIDS.

DEATH OF A BUSHMAN WOMAN, BOTSWANA



GAKEMEITSWE (NOT HER REAL NAME) WAS 29 WHEN SHE DIED OF AIDS, IN THE NEW XADE RESETTLEMENT CAMP, IN 2006. SHE LEFT THREE CHILDREN, TWO OF WHOM SHE HAD ADOPTED WHEN HER SISTER DIED OF TB. SHORTLY BEFORE HER DEATH, SHE SAID TO SURVIVAL, **‘I WANT TO GO AND BE BURIED IN MY HOME IN MOLAPO [IN THE CENTRAL KALAHARI GAME RESERVE, CKGR]. I AM SICK NOW, I AM ABOUT TO DIE... WE WERE THE FIRST PEOPLE FROM MOLAPO TO BE EVICTED. HERE IN NEW XADE THERE ARE DIFFERENT KINDS OF DISEASES THAT WE DO NOT RECOGNISE... WHEN YOU GET SICK, YOU DIE.’**

ALTHOUGH BOTSWANA HAS ONE OF THE HIGHEST HIV/AIDS RATES IN THE WORLD, BUSHMAN COMMUNITIES IN THE CKGR WERE BARELY AFFECTED. HOWEVER, RATES ARE INCREASING ALARMINGLY IN THE RESETTLEMENT CAMPS. GAKEMEITSWE’S FAMILY WAS EVICTED FROM THE RESERVE IN 1997. HER SISTER AND HER MOTHER HAVE ALSO DIED IN NEW XADE. ANOTHER SISTER IS NOW CARING FOR THE THREE ORPHANS, PLUS FOUR CHILDREN OF HER OWN.¹⁸

In 2002, the Yanomami, who had suffered the loss of 20% of their people through diseases brought in by miners, ranchers and loggers, faced a new threat, the construction of army barracks close to their land. There have been reports of sexual exploitation of Yanomami women and the spread of sexual diseases: ‘The soldiers have already brought gonorrhoea and syphilis with them, and we fear that if they continue to have sex with Yanomami women, they will transmit HIV’ (Davi Kopenawa Yanomami).¹⁹

Well-trusted health workers who have a long history with a community can be very effective at preventing STI transmissions. A nursing auxiliary with the Enawene Nawe warned the community of the ‘akoya kawé’, the diseases that could be spread by sexual contact, and explained about the use of condoms. When a road was built and some men were given the bribe of a visit to a brothel, the few that accepted insisted on using condoms.²⁰ To be successful, HIV/AIDS and STI awareness programmes need to be locally devised and culturally appropriate.²¹

‘The soldiers have already brought gonorrhoea and syphilis with them, and we fear that if they continue to have sex with Yanomami women, they will transmit HIV.’

Davi Kopenawa Yanomami

Chapter 5:

Healthcare



'Doctors in Papua are not saving lives. They prescribe drugs for our people when they are sick but when Papuans visit the chemists they cannot afford to buy the expensive medicines. They just go home sadly and wait to die. This is systematic genocide. Our land is rich so our people should have enough money to buy medicine to save their lives. Where is the money from our land going?'

Rev Herman Saud and Rev
Socratez Sofyan Yoman, 2005¹

'As the experience of many indigenous peoples illustrates, provision of health care in squalid 'resettlement camps' is not adequate recompense for the misappropriation of land and the denial of a lifestyle that is central to their concept of health and well being.'

Global Health Watch, 2005-6

'It is not development. They [the Jarawa] are losing their identity and their ways of living, which has enabled them to survive for these many years. They have begun their march on a road to extinction.'

Shekhar, 2003

THE HEALTH CARE MYTH

This report has shown some of the desperate health problems that tribal people suffer when they are removed from their land, denied the ability to practice their traditions and when their diet changes dramatically from a healthy, varied selection of wild foods to processed store-bought produce, rations, or the meagre pickings available in urban slums. In these environments, many tribal peoples experience such a worsening health situation that medical assistance is desperately needed. Yet healthcare in the grim relocation sites, urban peripheries and roadside shacks where many displaced tribal people end up, is usually unavailable, unaffordable and ill-suited to their needs.

Those tribal people who remain in control of their lands, able to practice their traditional livelihoods, such as hunting and gathering, and who retain some autonomy over their communities fare better. Of course they have health needs that cannot be met by their traditional healers, especially because of diseases brought from the outside, such as malaria and measles, and when they suffer problems that require surgery. But the most appropriate healthcare provision brings healthcare professionals and their medicines to communities rather than taking the patient – or worse still, uprooting the whole community – to urban centres, or to inadequate, poorly-resourced local hospitals.

There is a deep-set myth among many development specialists and governments that it is in tribal peoples' interests to be moved to less remote areas. A major reason given is that this enables the communities to access better healthcare. The question is raised: 'Don't we all want to be within easy access of good hospitals?' Often, governments use the disastrous impacts of first contact, such as epidemics, to further justify this simplistic argument.²

In Botswana, Bushmen have been the main targets of the 'Remote Area Development Programme' (RADP), which has aimed to 'develop' remote-living people and bring them closer to health and education facilities. 'The cumulative effects have been poverty, marginalisation, subjugation, alcohol abuse, poor basic health and education, exclusion from decision-making processes, social discrimination and prejudice, domination and control, and reliance [on non-Bushman groups]' (Nthomang 2004). The results have been neither 'development' nor 'healthcare'. The government itself has admitted that Bushmen removed to the New Xade settlement camp are dying from alcohol poisoning and liver cirrhosis.³ The residents of the camp are also dying of AIDS.

Healthcare development has also been used as a rationale for moving communities into more ‘appropriate’ housing, as with the Innu of Davis Inlet. The Innu, who traditionally lived in tents, were moved into poor-quality housing with no clean water or sewerage and which was not adequate to protect the new residents from the cold. The settlements were overcrowded and enforced a permanency alien to the Innu’s way of life. The relocation led to a rapid decrease in the physical health of the community. The change from a nomadic life in the interests of ‘healthcare’ led to a significant decrease in the wellbeing of the people concerned.⁴

Removing individuals to distant hospitals exposes them to further health problems, such as infectious diseases, which can then be brought back to the community when the patient returns. This is especially dangerous with people who maintain a high degree of isolation and therefore have low immunity to common ‘Western’ diseases. For individuals from isolated communities, the shock of landing up in a large hospital, in an urban area, staffed by people to whom your culture is totally alien, can certainly worsen their health.

Many remote-living indigenous people in the Americas and Australia have been removed from their communities for long periods in the name of healthcare. The patient suffers from cultural isolation and lack of family members. If enough people are removed in this way, there are resultant impacts on the whole community. To tackle the sudden desperate rise in TB among Inuit peoples, the Canadian government forced patients to evacuate from their homelands. Many were separated from their families and cultures for years and even decades.⁵ Women in remote communities in Canada and Australia were commonly removed

from their families when their babies were due and sent to hospitals for delivery and ‘confinement’, which interfered with traditional practices and rituals.⁶ Similarly, in Alaska, state policies for palliative care of the dying have separated patients from their communities. By sending the terminally ill away to distant hospitals to die alone, doctors deny them the physiological and psychological benefits of family support and ritual practices. By thus interfering with births and deaths, the medical system can catastrophically damage a culture.⁷

In Canada, TB patients have been evacuated from their communities for decades.

TREATING THE JARAWA OF THE ANDAMAN ISLANDS

DESPITE A 2004 DIRECTIVE THAT THE RECENTLY CONTACTED JARAWA SHOULD RECEIVE MEDICAL ATTENTION IN THEIR RAINFOREST HOME AND THAT THEY SHOULD ONLY BE MOVED TO A HOSPITAL IN AN EMERGENCY, A RECENT INVESTIGATION FOUND THAT JARAWA WERE STILL BEING ADMITTED TO HOSPITAL FOR SUCH MINOR REASONS AS COUGHS, COLDS AND CUTS.⁸ AS ENTIRE FAMILIES OF JARAWA USUALLY ACCOMPANY PATIENTS TO HOSPITAL, A GREAT NUMBER OF JARAWA ARE BEING PUT IN DANGER OF EXPOSURE TO DISEASE. BEING AN ISOLATED AND NUMERICALLY SMALL TRIBE, THEY ARE PARTICULARLY AT RISK FROM INFECTIOUS DISEASES, WHICH, IF BROUGHT BACK TO THEIR COMMUNITY, COULD ENDANGER THE SURVIVAL OF THE WHOLE TRIBE. WHILST IN HOSPITAL, THE JARAWA ARE GIVEN CLOTHES AND FOOD THAT ARE ALIEN TO THEIR CULTURE AND ARE MADE TO WASH WITH SOAP. CLOTHES CAN CAUSE SERIOUS PROBLEMS AMONG PEOPLES WHO HAVE NO TRADITION OF WEARING THEM, AS THEY OFTEN REMAIN UNWASHED, CAUSING SKIN DISEASES. MOBILE MEDICAL UNITS, WHICH OPERATED WITHIN THE JARAWA’S RESERVE, HAVE BEEN DISCONTINUED. BY INSISTING ON REMOVING THE JARAWA FROM THEIR LAND FOR UNNECESSARY MEDICAL INTERVENTION, THE ANDAMANS’ ADMINISTRATION IS PUTTING THE JARAWA IN DANGER NOT ONLY OF DISEASE, BUT ALSO OF DEPENDENCY.

‘IN ONE DAY WE EXPERIENCED TWO CONTACTS WITH JARAWA. THE FIRST TIME... THEY WERE SITTING ON HOSPITAL BEDS, CLOTHED IN ILL-FITTING GARMENTS OF RIDICULOUS COLOURS AND SHAPES, STARING VACANTLY AT THE VISITORS. CUT TO A DIFFERENT SCENE. IN THE NATURAL ENVIRONMENT OF... THE RAINFORESTS OF SOUTH ANDAMANS AT POONA NULLAH. WE SAW THEM, VITAL AND ENERGETIC, UNENCUMBERED WITH CLOTHES, HOLDING BABIES, MAKING HUNTING IMPLEMENTS, CELEBRATING THE ARRIVAL OF A FRESH SHIKAR [HUNT]. ... WHAT LINGERED IN OUR MIND WAS HOW PROUD AND HAPPY THEY LOOKED, UNLIKE THE COWERING SCENE OF THE HOSPITAL.’⁹

A CLASH OF CULTURES

‘The healthy future of these groups depends on socio-economic and sociopolitical factors such as access to education and the acknowledgement of traditional rights. Medical assistance to cope with the malnutrition and diseases of these people would calm the symptoms, but should not preclude other more wide-ranging interventions, considering the ecological, social, political and economic drivers of change that indirectly affect the health of forest people. Improving their health is not in the hands of medical doctors alone.’

AusAID, 2005

Many healthcare practitioners have an inherent belief in the superiority of Western medicine and a lack of understanding of local indigenous methods of healthcare and traditional concepts of wellbeing, health and holistic care. Worse still, some mission organisations have sought to ban shamanic systems of healthcare as ‘witchcraft’ and ‘devil worship’ without an understanding of how integral such systems are to the cultures concerned.¹⁰

This gulf of understanding leads to complex problems when external systems of healthcare are imposed on tribal peoples. Deep-rooted concepts of shame and appropriateness may be disturbed when, for example, a female nurse washes an initiated male elder or a male gynaecologist examines a woman.

Sudden influxes of immunisation teams may cause panic if their motivations and methods are not carefully explained. It is vitally important that external health agencies explain all their intentions to the communities that they serve, work hard to learn from and adjust to local sensitivities and accept that sometimes their procedures or explanations may be inappropriate.

‘Rigidly adhering to a western-based view of health may in fact do more harm than good, [because of]. ... the marginalization (or even criminalization) of traditional practitioners, ... [There is a need for] a bridge to local views about health, illness and treatment’ (Colfer et al 2006).

ACCESSIBILITY, AFFORDABILITY AND DISCRIMINATION

Mainstream ‘Western’ medical services, even where relocated tribal people can reach them, are often inaccessible because of the costs involved. Increasingly, medical care in poorer countries carries user fees, which impoverished tribal people cannot afford. In Cambodia, indigenous women reported costs (both transport and doctors’ fees) to be a major barrier to accessing healthcare and experienced having to buy medicines at expensive private pharmacies run by the families of hospital staff in order to receive treatment.¹¹

Even where healthcare is affordable, there are often problems of discrimination against indigenous communities. In Burundi and DRC, Twa (Pygmy) women have had to pay bribes to get healthcare staff to treat them. Some say that health workers discriminate against them, saying that they ‘smell’

or are ‘dirty’.¹² San in Namibia have reported such rudeness, mistreatment and intimidation from nurses in health centres that it puts them off seeking help.¹³ In South America, Indian communities are ‘generally at the very fringes of outreach programs. Indeed, even those programs that do extend into indigenous areas may fail because racist attitudes among healthcare providers greatly limit access to services and because the programs are designed with the incorrect assumption that human groups are culturally and biologically homogeneous’ (Hurtado et al 2005:642).

In British Columbia, First Nations women have mortality rates 4-6 times the provincial average for cervical cancer. They attend cervical cancer screening programmes less often than their non-indigenous neighbours, and find it hard to access culturally suitable health services.¹⁴

Language and cultural barriers, combined with discrimination, often result in a lack of communication between medical staff and indigenous patients. In Peru in April 2006, several Pueblo Nuevo women from the eastern Amazon region of Ucayali, were sterilised in a health centre without explanations either of the nature of the operation or the need for rest and post-operative care. The women returned to their normal high level of activities and four developed serious infections.¹⁵

PAPUAN HOSPITALS: **PLACES OF LAST BREATH**

THE PAPUAN PEOPLES OF THE ISLAND OF NEW GUINEA HAVE SUFFERED TERRIBLY SINCE INDONESIA OCCUPIED THE WESTERN HALF OF THE ISLAND IN 1963. THE INDONESIAN ARMY HAS A LONG HISTORY OF HUMAN RIGHTS VIOLATIONS AGAINST THE PAPUANS, AND RACIST INDONESIAN SOLDIERS GENERALLY VIEW THE PAPUAN PEOPLE AS LITTLE MORE THAN ANIMALS. PAPUA'S NATURAL RESOURCES ARE BEING EXPLOITED AT GREAT PROFIT FOR THE INDONESIAN GOVERNMENT AND FOREIGN BUSINESSES, BUT AT THE EXPENSE OF THE PAPUAN PEOPLES AND THEIR HOMELANDS.

THE HEALTH OF THE PAPUAN PEOPLES CONTRASTS SHARPLY WITH AVERAGES FOR INDONESIA: THEIR LIFE EXPECTANCY IS ONLY 50 YEARS AND 170 INFANTS PER 1,000 DIE BEFORE THE AGE OF FIVE, COMPARED WITH ONLY 50 INFANTS ON AVERAGE IN INDONESIA. THE PAPUANS, EXPOSED TO COUNTLESS ILLNESSES IMPORTED BY OUTSIDERS, DO NOT HAVE ACCESS TO HIGH STANDARDS OF HEALTHCARE. ON THE CONTRARY, HEALTHCARE HAS BEEN DESCRIBED AS 'HELL' BY PAPUAN LEADERS DOLLY ZONGGANAU AND JOHN RUMBIK. THE CLEANING OF EVEN THE SURGICAL WARDS FALLS TO THE PATIENTS' RELATIVES AND THERE ARE SERIOUS COMMUNICATION PROBLEMS BETWEEN INDONESIAN STAFF AND PAPUAN PATIENTS. MANY PAPUANS ARE DISTRUSTFUL OF HOSPITALS, BELIEVING THEM TO BE A PLACE OF 'LAST BREATH'.¹⁶

' First they make us destitute by taking away our land, our hunting and our way of life. Then they say we are nothing because we are destitute.'

Jumanda Gakelebone, Gana Bushman, Botswana, 2007

SURVEY ON AIDS IN BOTSWANA

A STUDY IN 2007 BY MOSWEUNYANE IN BOTSWANA, EXPLORED EXPERIENCES AND KNOWLEDGE OF HIV/AIDS AMONG THE BUSHMAN POPULATION. HIV/AIDS WAS SEEN AS AN ALIEN DISEASE, BROUGHT IN BY THE BATSWANA [NON-BUSHMAN BOTSWANANS], OFTEN THROUGH RAPE. RAPE WAS NOT OFTEN REPORTED, BECAUSE **'WE FEAR THE COPS BECAUSE THEY SAY WE EMIT BAD SMELL, WE ARE DRUNK AND WE ARE NOT FLUENT IN SETSWANA [THE NATIONAL LANGUAGE]. SOMETIMES THEY JUST LAUGH.'**

INFORMATION ABOUT AVOIDING, TESTING AND TREATING THE DISEASE WAS FAILING TO REACH THE BUSHMEN, PARTLY BECAUSE OF THE NEGATIVE ATTITUDES OF BATSWANA TOWARDS THE BUSHMEN. INTERVIEWEES FROM THE HEALTH SECTOR REFERRED TO BUSHMEN AS: 'VEXATIOUS, TROUBLESOME DRUNKARDS; VERY STUBBORN, [THEY] DO NOT CO-OPERATE; VERY INSOLENT PEOPLE; VERY NOISY PEOPLE.' BUSHMAN INTERVIEWEES FOUND IT HARD TO ACCESS INFORMATION, WHICH WAS NOT AVAILABLE IN THEIR LANGUAGES, AND FOUND THE GOVERNMENT SERVANTS INTIMIDATING; ONE SAID, 'THEY ARE THE PEOPLE WHO BROUGHT THE DISEASE TO US BUT NOW PRETEND TO CARE AND TEACH US WHEN THEY KNOW WE ARE ALREADY INFECTED AND DYING.' WHEN ASKED WHAT KIND OF HEALTH PROJECT WAS NEEDED, A CLEAR FOCUS WAS ON THE NEED FOR INFORMATION IN THEIR OWN LANGUAGE, FROM THEIR OWN PEOPLE. ONE CLEAR RESPONSE WAS, **'WE WANT TO BE RETURNED TO OUR ANCESTRAL LAND BECAUSE WE WERE NOT ABUSED BY THE PEOPLE FROM CITIES/TOWNS AND BOERS (WHITE FARMERS) LIKE IT IS AT THE MOMENT IN NEW XADE [RESETTLEMENT SITE].'**¹⁷

HEALTHCARE BY THE PEOPLE, FOR THE PEOPLE

URBANA

Yanomami healthcare project – set up in the 1990s –
reduced the number of Yanomami deaths by half.

There does not have to be a trade off for indigenous people between living on their lands and having access to decent, effective healthcare. Nor do indigenous healers have to be replaced by western doctors. Over centuries, tribal peoples have developed complex health systems, combining spiritual and herbal healing.¹⁸ Underlying such systems is an intricate and extensive knowledge of medicinal plants and their uses.¹⁹ In fact, a substantial proportion of the western world's pharmacopoeia is based on tribal use of medicinal plants or other substances.

Tribal approaches to healing typically focus on the interconnections between the individual, family and community and see physical, mental and spiritual health as inseparable. This contrasts heavily with western medicine's focus on a patient and his/her specific symptoms and is far more appropriate for the complex problems faced by displaced

communities, including alcohol abuse, suicide and diabetes. In these situations, the health of the individual is best achieved through community-level changes. Although traditional healers cannot cure all the ills that contact with the West brings, nor can Western doctors, and tribal healers remain vital for the wider wellbeing of the community. It is essential that their work is respected and augmented by any external medical system, rather than dismissed and replaced.

Even very remote communities can have affordable health projects run by them and for them, with help from trained staff from outside. With time, these outsiders can share their skills and knowledge with the community, and interested locals can be sent on training programmes, and an effective local healthcare system can be established. A major difference with such projects lies in their underlying attitude: the local people are seen as both capable

of helping themselves and as the most appropriate people to deliver healing. This runs totally counter to the paternalistic attitude of many government or mission-run health projects, which assume the superiority of 'Western' knowledge and skills. There are an increasing number of examples of effective, appropriate healthcare projects among indigenous communities.

**The most effective
health projects build
on indigenous knowledge
with targeted training.**



'BEFORE THE WHITES ARRIVED, WE WERE NOT IGNORANT. OUR SHAMANS WERE ABLE TO HEAL US. WHEN THERE WAS NO WHITE MEDICINE THE SHAMANS DID THEIR WORK AND ONLY A FEW PEOPLE DIED YOUNG. NOW THAT THE WHITES HAVE COME TO OUR FOREST, WE ARE AFRAID OF MALARIA AND TUBERCULOSIS, WE ARE AFRAID OF THE XAWARA [CONTAGIOUS DISEASES] THAT THEY LEFT BEHIND. THOSE DISEASES COME FROM AFAR, OUR SHAMANS DO NOT KNOW THEM. OUR SHAMANS' SPIRITS CAN ONLY DESTROY THE DISEASES THAT WE KNOW. WHEN THEY FIGHT THE XAWARA BY THEMSELVES, IT CAN KILL THEM TOO. TO WARD OFF THOSE DISEASES, WE NOW NEED THE WHITE MAN'S MEDICINE. BUT WE DON'T KNOW HOW TO READ THE WHITE MAN'S PAPERS, WE DON'T KNOW HOW TO USE HIS MEDICINES. WE NEED YOU TO TEACH US HOW TO USE YOUR MEDICINE AGAINST MALARIA, TUBERCULOSIS, AND OTHER DISEASES. THEN, WHEN OUR YOUNG MEN KNOW EVERYTHING, WE WILL BE ABLE TO HEAL OURSELVES, BY OURSELVES.' Davi Kopenawa Yanomami, 1997

THE YANOMAMI HEALTH PROJECT



The Yanomami of the Amazon rainforest have been plagued by measles, malaria and violent attacks since roads were first cut into their territory bringing labourers and goldminers and decimating their population. In 1987, one Yanomami person was dying every day from diseases introduced by the outsiders, and by 1989 there were 40,000 miners in Yanomami territory. The government, wanting to hide the terrible situation, cut medical assistance to the area and evicted all independent observers, including non-governmental health workers.²⁰

In the seven years up to 1993, one fifth of the Yanomami were killed either by disease or in violent attacks by goldminers. In 1991, a health survey found that 35% of the Yanomami were malnourished, 76% anaemic and 13% of the children had lost one or both parents.²¹ In some areas, over 90% of the Yanomami were infected with malaria and 70% had viral respiratory diseases.²² The government's health facility for the Yanomami was the Casa do Indio ('Indian House') in Boa Vista, where malarial patients were treated and simultaneously subjected to 'appalling medical, nutritional and sanitary conditions' and infection by further diseases (AAA 1991).

The Yanomami leader, Davi Kopenawa Yanomami, first suggested that his people needed their own, autonomous health project in 1989. Even after their land was finally demarcated in 1992 and the miners expelled, the health problems persisted. Government health projects had been short-lived, ineffective and inappropriate. A Yanomami-led project was needed to stop 'drawing the Yanomami to gather and live permanently around the FUNAI [national Indian agency] post and missions, which deepens

their dependency, diminishes their cultural identity and worsens their health conditions' (CCPY 1991:9).²³ Instead, an independently-funded project was built around close co-operation between health teams and shamans, and most importantly, continuous healthcare coverage in the villages.

Whilst it was run by the NGO Urihi, the Yanomami health project was especially effective in combating suffering and deaths from malaria. By 1999, Urihi had reduced rates of TB by 60%, infant mortality by 65% and malaria by 99%, compared with 1991 figures. In the first six months of 2000, mortality fell by over 50%.²⁴

However, in 2002, the government restricted funds to the project. Leaders pleaded 'we Yanomami need Urihi to continue working with us', but in 2004 the government took over the project. Malaria quadrupled from 418 cases in 2003 to 1,645 in 2005, despite the government spending twice as much money on providing health care in the Yanomami area as Urihi.

In an open letter, leaders of seven Brazilian Indian organisations wrote: 'We want to participate actively and have close control over healthcare in our indigenous areas, because we know our reality and the needs of the communities we represent... We do not accept that a non-indigenous organisation... with no experience of working with indigenous peoples' health, can take over indigenous healthcare.'²⁵



HEALTHCARE AND THE ENAWENE NAWE

THE HEALTH PROBLEMS AND SUFFERING THAT THE ENAWENE NAWE HAVE FACED THROUGH CONTACT WITH OUTSIDERS HAS NOT LED THEM TO WANT TO MOVE CLOSER TO TOWNS AND HOSPITALS, ALTHOUGH THIS WAS CERTAINLY DISCUSSED IN THE COMMUNITY. THEY REALISED THE DANGER OF DEPENDENCE ON OUTSIDERS, AND ASKED THAT, IN ADDITION TO PRIMARY HEALTHCARE FROM THE NGO OPAN (OPERAÇÃO AMAZÔNIA NATIVA), COMMUNITY MEMBERS SHOULD RECEIVE HEALTH TRAINING, 'SO THAT WE DO NOT BECOME FRIGHTENED WHEN THE INUTI [OUTSIDERS] ARE NOT IN THE VILLAGE.' THE ENAWENE NAWE HAVE A SOPHISTICATED AND COMPLEX SYSTEM OF HEALTH CARE, INCLUDING HERBALISTS, SHAMANS AND MASTERSINGERS, YET HAD REALISED THEY NOW ALSO NEEDED SOME 'WESTERN' MEDICINES BECAUSE OF THE ARRIVAL OF OUTSIDERS' ILLNESSES. THEY HAD A NAME ALREADY PREPARED FOR THESE NEW SPECIALISTS TO BE TRAINED, 'BARAITALIXI', OR 'LITTLE HERBALISTS'.

PART OF THE SUCCESS OF THE BARAITALIXI PROJECT LIES IN THE WAY IT HAS INTEGRATED THE DIVERSE NEEDS OF THE COMMUNITY. THE ENAWENE NAWE WERE DEVELOPING THEIR WRITTEN LANGUAGE, AND WERE KEEN TO USE THE PROJECT'S HEALTH DATABASE AND INFORMATION FOR THIS. THE GENERAL EDUCATION PROGRAMME INVOLVED EXTENSIVE DISCUSSION OF THE POLITICS OF HEALTH. THE TRAINING OF THE BARAITALIXI WAS CONDUCTED IN THE LONGHOUSES, IN THE ENAWENE NAWE LANGUAGE, AND IN THE PRESENCE OF EVERYONE. WITH THE PROJECT WELL UNDER WAY, THE BARAITALIXI, SUPPORTED BY ACCESS TO HEALTHCARE PROFESSIONALS BY RADIO, WERE ADVISING AND TREATING UP TO 80 CASES A MONTH.

THE LOCAL HOSPITAL HAS INSTALLED A SPECIAL WARD FOR INDIGENOUS PEOPLE, WITH HOOKS FOR HAMMOCKS, SPACE FOR PEOPLE TO STAY, AND BASIC ANTHROPOLOGY COURSES FOR HOSPITAL STAFF. THIS MEANS THAT WHEN PEOPLE NEED EMERGENCY EVACUATION, THEY ARE NOT FEARFUL OF INADEQUATE, DISCRIMINATORY CARE.²⁶



There have been examples where government funded projects have been effective in working together with tribal communities to provide appropriate and culturally sensitive healthcare, especially those that have community involvement as a fundamental principle. However, money and progressive policies by decision makers alone are not enough to make projects successful. Brazilian law on indigenous healthcare is very progressive with indigenous peoples themselves supposedly playing an active role in the provision. However, without the political will to make these policies a reality, or appropriate training for healthcare staff who are willing to work with the community on their terms, government-led health projects have tended to fail.

STRONG CULTURES, HEALTHY PEOPLES

Community-designed and run projects are also the most effective way of tackling the mental health problems that many displaced indigenous peoples face. Suicide, alcohol abuse, domestic violence, depression and vandalism are not easy problems to solve. State-run programmes do not boast high success figures. Yet a protection against – and a cure – for such situations is continuing interaction with the land and the culture, known as ‘cultural continuity’. The least damaged individuals in relocated communities are usually those who continue to return to the land and/or practice seasonal hunting and gathering. This connection with their own identity, and a continued reliance on traditional skills and knowledge, reduces the sense of dislocation and dependence. Young, disaffected individuals who may be struggling at school and be disruptive and abusive, can experience profoundly improved behaviour and self-esteem when reconnected with their land and culture, with long-term benefits for their mental health.

THE TSHIKAPISK FOUNDATION: RECONNECTING WITH INNU CULTURE

‘WHEN WE ARE IN THE COUNTRY, WE FEEL HEALTHY. WE LOVE TO BE IN THE COUNTRY WHERE WE ALWAYS HELP EACH OTHER... THIS IS A WONDERFUL WAY TO LIVE.’

GROUP OF INNU CHILDREN, 1992

THE INNU VILLAGE OF SHESHATSHIU IS RINGED BY A GROUP HOME, WOMEN’S SHELTER, SOLVENT ABUSE CENTRE, CLINIC AND ALCOHOL PROGRAMME – ALL EVIDENCE OF THE CANADIAN GOVERNMENT’S RESPONSE TO THE HIGH RATES OF SUICIDE, DRUG ABUSE AND DYSFUNCTIONAL BEHAVIOUR IN THE COMMUNITY. THESE CLINICS REFLECT THE GOVERNMENT’S APPROACH: THAT THE PROBLEMS THE INNU ARE FACING ARE THE PROBLEMS OF INDIVIDUALS OR FAMILIES, BEST DEALT WITH BY DRUGS, COUNSELLING AND LARGELY IMPORTED HEALING RITUALS.

BUT MANY INNU BELIEVE THAT THIS APPROACH DOES NOT DEAL WITH THE ROOT CAUSES OF THEIR PROBLEMS AND HAVE BEGUN TO LOOK FOR INNU-LED SOLUTIONS THAT ARE ROOTED IN THEIR HISTORY, CULTURE AND TRADITIONS, RATHER THAN FOCUS ON INDIVIDUALS. A GROUP OF INNU HUNTING FAMILIES RECENTLY ESTABLISHED THE TSHIKAPISK FOUNDATION, MOTIVATED BY FRUSTRATION WITH GOVERNMENT CLINICS AND BY A DESIRE TO LEAD HEALTHIER AND MORE PRODUCTIVE LIVES ON THE LAND. THROUGH THE FOUNDATION, YOUNG INNU HAVE BEEN TAUGHT THE HISTORY OF THEIR PEOPLE, THE GEOGRAPHY OF THEIR LANDS AND THE PRACTICAL SKILLS NEEDED TO LIVE IN THE COUNTRY. THE PROJECT KEEPS INNU SKILLS ALIVE AND STRENGTHENS A SENSE OF INNU IDENTITY AND THE TRADITIONAL CONNECTION OF THE INNU PEOPLE TO THE LANDS, WATERS AND ANIMALS AROUND THEM.

THE STUDENTS HAVE TO WORK HARD, WALKING UP TO 20 KILOMETRES A DAY OVER EXTREMELY RUGGED TERRAIN CARRYING HEAVY LOADS. THEY RETURN TO THE COMMUNITIES HEALTHIER AND STRONGER. YOUNG INNU WHO ARE FREQUENTLY REGARDED AS ‘FAILURES’ IN THE VILLAGE ON ACCOUNT OF THEIR LACK OF ACHIEVEMENT IN THE SCHOOL SYSTEM, OFTEN PERFORM WELL IN THE PRACTICAL AND SOCIAL SKILLS NEEDED IN THE COUNTRY. PETROL-SNIFFING YOUTH WHO ARE TAKEN OUT TO THE COUNTRY RETURN WITH VASTLY ENHANCED SELF-ESTEEM AND CONFIDENCE.

‘I FEEL A LOT BETTER ABOUT MYSELF OUT HERE IN THE COUNTRY.

[BACK] IN SHESHATSHIU ALL I DO IS DRINK... I LIKE IT HERE.

IT’S PEACEFUL. THERE ARE NO DRUNKS OR DRUGS.’

Jonathan Walsh, Innu youth at Kapuamaskat camp, 2006

Conclusion

'I am not saying I am against progress. I think it is very good when whites come to work amongst the Yanomami to teach reading and writing and to plant and use medicinal plants. This for us is progress. What we do not want are the mining companies, which destroy the forest, and the garimpeiros, who bring so many diseases. These whites must respect our Yanomami land. The miners bring guns, alcohol and prostitution and destroy all nature wherever they go. For us this is not progress. We want progress without destruction.'

Davi Kopenawa Yanomami

There are three vital points that this report has made regarding tribal peoples' health. Firstly, rights over land and the ability to maintain traditions and 'cultural-continuity' on that land are crucial for good health. Secondly, removal from the land, or other forms of imposed 'progress', have devastating impacts, both initially and in the long-term. Thirdly, whilst external systems of healthcare are necessary to help tribal peoples to fight introduced diseases, they can cause more damage than good; appropriate health projects need to be carefully devised with, by, and for the people concerned.

1. Land rights protect health

Tribal people, living according to their traditions, on their own land, are typically healthy, happy, strong and vibrant, with low levels of the chronic diseases that plague western societies. Their health can be largely attributed to three factors: high levels of exercise, diets based on a wide range of wild foods (rather than processed produce) and low levels of 'stress', due to strong communities and self-sufficiency. Sudden changes to their environment and society and contact with outsiders and their diseases lead to sharp increases in death rates: historically up to 90% of indigenous groups have been wiped out on contact. Contact kills in three ways: epidemics of diseases; shock and the resulting breakdown of coping mechanisms and food production;

and violence. The impacts are far less severe where the tribe maintains control over their land - the source of their health. But where control over the land is lost, or where tribal peoples are prevented from using their land according to their traditions, long-term health suffers. The three factors that contribute most to health – diet, exercise and self-sufficiency – depend on access to the land. People who have been removed from their land almost always lose their self-sufficiency, depending instead on handouts, wage labouring or the sale of goods to markets (or, in the worst cases, on scavenging). Their diet changes from being based on wild, collected foods, to processed foods or agricultural foods, their exercise levels change and their stress levels rise. Access to traditional medicines and the healing powers associated with the spiritual connection to the land are lost.

2. Health impacts of contact and loss of land are long-term

The immediate health impacts of contact and removal from the land are clear, but there are also dramatic long-term impacts. When removed from their land, tribes are often forced into slums and squatter camps, where crowding can be a real problem, especially for groups that were previously nomadic and lived in small family groups, like the Nukak. Such sedentarisation leads to exposure to diseases typical in poor, crowded conditions: water-borne diarrhoeal diseases and epidemics of 'common'



diseases, such as flu and chicken pox, and to diseases carried by animals and by dirty clothing. For infants in particular, this can lead to high mortality rates.

Even in more wealthy countries, aboriginal peoples often suffer the worst of these ‘diseases of poverty’ and the chronic diseases that come with ‘Westernisation’: diabetes, high blood pressure, obesity and cancers. Diabetes has become a major threat to the health of tribal peoples due to massive changes in diet and exercise levels and an increase in stress coupled with a decrease in self-sufficiency.

These changes lead, almost inevitably, to mental distress. For the older generation, adaptation is harder and is often coupled with a profound sense of disorientation. Elders also lose their status as communities are fragmented by the changes imposed upon them; alcoholism is an all-too-common symptom of their suffering. For the young, the loss of their imagined future and imposed, alien schooling – especially residential schooling – can be so unsettling that they are left aimless. They may feel alienated from the mainstream, often suffering from racism, and yet also dislocated from their communities. Rates of youth suicide and substance abuse are alarmingly high among tribal groups that are no longer living on their own land. However, where communities are still living largely through their traditions on their own land, or where they have managed to return to their lands, suicides are rare or totally unknown.

An increasingly worrying threat to the health of tribal people is HIV/AIDS. Several factors contribute to sudden increases in infection among dislocated tribes: contact with outsiders leads all too often to the sexual exploitation of tribal women and girls; increased dependence

on distant labouring means that men are away for long periods, often returning with the virus; and the breakdown of communities destroys social taboos that might have protected people against infection, such as taboos against sexual relations with outsiders.

3. Healthcare must be appropriate

Where tribal peoples have been exposed to outsiders’ diseases and, especially, where their lives have been in turmoil due to externally imposed changes, they will be exposed to diseases that their traditional medical systems will not be able to cope with. They need good healthcare, especially vaccination programmes and access to dental care and sexual health programmes. But healthcare can be more damaging than healing if it involves the long-term removal of communities and/or patients from their land, if it destroys faith in traditional healing and healers, if it is poorly explained and aggressively implemented and if it is delivered by abusive, racist staff. All these ‘ifs’ are very common.

Healthcare programmes that are requested by the community and developed with them, on their land, uniting indigenous traditions of healthcare with ‘Western’ medical assistance can be very positive, leading not only to improved health, but to renewed pride and confidence among the community. The best projects aim to enhance, rather than remove, the community’s self-sufficiency by training people to cope independently and also provide accessible, affordable, non-discriminatory backup healthcare for situations beyond local capabilities. Similarly, the most effective programmes for mental health problems involve reuniting young people with their land,

their culture and their sense of identity. While government-run ‘detox’ programmes may help a substance-abusing teenager in the short-term, these community initiatives get to the heart of the problem and therefore enable long-term solutions.

Through our involvement in projects, such as the Tshikapisk Foundation and the Yanomami Health Project, Survival has seen their potential for good. But the majority of tribal peoples around the world are suffering desperate ill-health from the impacts of ‘progress’ and the loss of their land. Peoples such as the Nukak in Colombia, the tribes of West Papua and the recently contacted Jarawa of the Andaman Islands, face the real risk of complete decimation if their land rights and cultural rights are not recognised and upheld. Please join our campaign to help them.

For more information about how you can help the tribes featured in this report, and to pledge your support, go to: www.survival-international.org/progresscankill.



ACT NOW

We are constantly monitoring the situation of tribal peoples around the world, with a particular focus on the most vulnerable, often those who have least contact with outsiders. We ask concerned people to take action as soon as a specific threat is identified. Many can be averted either by public pressure or by financing health, educational or self-help projects.

Since 1969, the movement we have created has repeatedly proved its effectiveness in saving tribal lands and preventing some of the most extreme catastrophes. Joining the movement for tribal peoples is easy and carries with it no obligation whatsoever. You can elect to receive as much or as little information as you wish:

- For free and brief monthly enews bulletins, sign up at www.survival-international.org/enews.
- To receive additional information by post, please contact us by email: info@survival-international.org, or by telephone: 020 7687 8700. You are invited to donate a minimum of £10 or equivalent a year for mailings. (We do not pass on your address or email to anyone.)
- Monitor our website www.survival-international.org frequently. Breaking news is posted there as soon as it is received, often with video. The website hosts Tribal Channel, blogs, podcasts, news feeds and other new ways of keeping you in touch with tribal peoples.

www.survival-international.org

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**We help tribal peoples defend
their lives, protect their lands
and determine their own futures.**

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Photo credits: cover Yanomami father and son, Brazil © Victor Englebort 1980/Survival; inside cover Yanomami mother and child, Brazil © Antonio Ribeiro; p4 Yanomami father and son, Brazil © Peter Frey/Survival; p5 Nambiquara mother and child, Brazil © Marcos Santilli/Panos Pictures; p7 Jarawa child, Andaman Islands © Salomé/Survival; p8 Illegal logging in the Penan forests, Sarawak, Malaysia © Ben Gibson; p9 Guarani camp, Brazil © Survival.

CHAPTER 2

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Photo credits: p11 Aborigine couple, Australia © Ceanne Jansen/Survival; p12 Aborigine woman, Australia © Mikkel Ostergaard/Panos; p14 Punan man, Borneo © Edward Dounias; p16 Enawene Nawe fishermen, Brazil © Fiona Watson/Survival; p17 Innu woman, Canada © Dominick Tyler/Survival.

Life expectancy

Two times more likely to die as a childⁱ

Three times more likely to die of avoidable causesⁱⁱ

Seven times more likely to die of diabetesⁱⁱⁱ

Nineteen times more likely to die from rheumatic fever and rheumatic heart disease^{iv}

Their life expectancy at birth is ten to fifteen years less than other Australians.^v

Life expectancy Graph^{vi}

HIV/AIDS

In 2015, 11 cases of HIV were confirmed in Matsigenka communities. Health officials say the outsiders are responsible for the rise in prostitution.^{vii}

Indonesian occupation is disastrous for Papuan tribespeople, who suffer 15 times the national rate of HIV/AIDS.^{viii}

Official cases of AIDS in West Papua Graph^{ix}

Starvation

Malnutrition is rife. From 2005 to 2015 at least 86 Guarani children died as a result.^x

Agribusiness has destroyed the forest which used to provide Guarani with their food, but when the Indians take back their land, malnutrition drops.^{xi}

Ethiopia's Kwegu tribe hunt, fish and grow crops alongside the Omo River. For centuries, this self-sufficient people thrived in a country renowned for famines. But now they are starving: their land has been stolen to make way for development projects, such as vast agricultural plantations.^{xii}

Obesity

In Australia, 37% of urban Aboriginal children are obese or overweight by 24 months old.^{xiii}

Indigenous children in some parts of Canada are 15 times more likely to suffer from type 2 diabetes than other Canadians.^{xiv}

Suicide

Brazil's Guarani tribe has a suicide rate 34 times the national average.^{xv}

In Canada, some indigenous groups who have lost their connection to their land have suicide rates 11 times the national average; those with strong links often see no suicides at all.^{xvi}

In Brazil, at least 72 Guarani-Kaiowá Indians killed themselves in 2013 – the highest suicide rate in the world.^{xvii}

Suicide rates for men aged 15-24 years graph.^{xviii}

Baka from Cameroon, illegally evicted in the name of conservation, often end up receiving alcohol as wages.^{xix}

Land is life

The Dongria Kondh grow over 100 crops and harvest 200 wild foods, providing a highly nutritious diet even in times of drought.^{xx}

India's Jarawa tribe have only had friendly contact with their neighbors since 1998. Experts described their nutrition as "optimum"^{xxi} and said they "enjoy a life of opulence."^{xxii}

When uncontacted Mashco-Piro Indians came out of the forest in Peru, they appeared robust and healthy and were filmed laughing and joking with local Yine Indians.^{xxiii}

Health and freedom

Some peoples, particularly in Australia and North America, are now trying to rekindle in their youngsters a connection to, and appreciation for, their lands and traditions, links which had been obliterated over recent generations. Such links have been shown to reduce addictions and help prevent suicides.^{xxiv}

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Photo credits: p 23 Nukak, Colombia © David Hill/Survival; p26 Grieving Guarani family, Brazil © João Ripper/Survival.

CHAPTER 4

- ¹ Quoted in Jackson 2006:39
- ² This was led by the NGOs Conselho Nacional Indigenista (CIMI) and Operação Anchieta (now Operação Amazônia Nativa, OPAN)
- ³ Personal communication from Heggy Wyatt, 2006, a nurse/anthropologist, who worked with the Enawene Nawe for 41/2 years as a health worker with OPAN/UNAIS
- ⁴ Unicef 2002
- ⁵ Brown et al 2006
- ⁶ Amnesty International USA 2006. See <http://www.amnestyusa.org/news/document.do?id=ENGUSA20060711003>
- ⁷ Chamberlain and Barclay 2000; Jasen 1997
- ⁸ Shepard and Rode 1996; Wirsing 1985; So 1980
- ⁹ Bourne 2003
- ¹⁰ Brundige et al 2004
- ¹¹ Butt 2002; Butt 2001
- ¹² Source: Directorate General Communicable Diseases and Environmental Health, Dept. of Health, Republic of Indonesia, 5 October 2004. See <http://www.papuaweb.org/dlib/tema/hiv-aids/index.html>
- ¹³ A conservative estimate could be calculated by multiplying known cases by at least 30, given the unavailability of HIV/AIDS tests and the number of cases that are never identified and added to the official statistics. In Wamena, in the Highlands, one nurse reported several AIDS deaths a month, but she was unable to test any of the patients due to lack of funds and tests. The official statistics suggest that there have been 14 HIV positive cases in the town since 2004, clearly a grossly inaccurate figure (Leslie Butt, personal communication 2006)
- ¹⁴ Nethy Dharma Somba 2004 'HIV/AIDS now major threat to Papuan tribes'
- ¹⁵ Wing and King 2005
- ¹⁶ Quoted in Laksamana.net October 2002.
- ¹⁷ Nethy Dharma Somba 2004 'AIDS decimating two Papuan tribes'
- ¹⁸ Gakemeitswe spoke to Survival shortly before she died. She wanted her story to be told. Her family requested, however, that her real name should not be used
- ¹⁹ Quoted in Rohter 2002
- ²⁰ Heggy Wyatt 2006, personal communication.
- ²¹ Weaver 1999; Pellegrine et al 1998

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CHAPTER 5

- ¹ Saud et al 2005
- ² It is important to note also that reports of significant improvements to hunter-gatherers' health with settlement must be treated with caution. Pre-contact or pre-sedentarisation statistics are often completely lacking, or skewed by small population sizes
- ³ Botswana Government Daily News 23 March 2006 'FPK allegations baseless ministry'
- ⁴ Samson and Pretty 2006; Denov and Campbell 2002
- ⁵ Bjerregaard et al 2004
- ⁶ MacCallum 2005
- ⁷ Decourtney et al 2003
- ⁸ Investigation by the Sub-group of experts on the Jarawa to the National Advisory Council 2006
- ⁹ Sub-group of experts on the Jarawa 2006
- ¹⁰ IWGIA 1989; Pollock 1988
- ¹¹ Brown et al 2006
- ¹² Jackson 2003
- ¹³ Suzman 2001
- ¹⁴ Health Canada 2001:33
- ¹⁵ Information collected by the Peace and Hope Association of Peru, Salazar 2006
- ¹⁶ See Saud et al 2005
- ¹⁷ Mosweunyane 2007
- ¹⁸ Renato 2006; Renato 1994
- ¹⁹ See, for example, Miliken and Albert 1999, on the ethnobotanical knowledge of the Yanomami.
- ²⁰ Rabben 1998:91
- ²¹ Rabben 1998:95
- ²² CCPY 1991:8
- ²³ CCPY is the Commission for the Creation of the Yanomami Park
- ²⁴ Instituto Socioambiental 2000
- ²⁵ See Survival 2006 (<http://www2.survival-international.org/news.php?id=1504>)
- ²⁶ Wyatt 2001; Personal communication with Heggy Wyatt, 2006
- ²⁷ Samson and Pretty 2006

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