



Africa

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East Africa

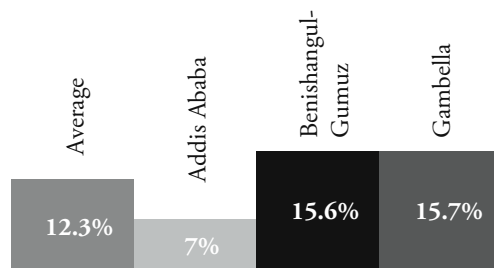
Laura A. Young

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

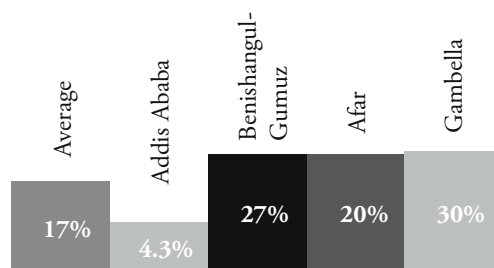
Ethiopia

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

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



Under-five mortality rate in Ethiopia



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

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

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

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

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

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

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

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

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

Kenya

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

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

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

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

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

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

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

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

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

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

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

Somalia

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

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



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

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

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

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

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

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

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

South Sudan

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

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Case study by *Chelsea Purvis*
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Ogiek in Kenya

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

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

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

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

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

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

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

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

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

Below: An Ogiek family in Kenya.

Ishbel Matheson/MRG.



Case study continued

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

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

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

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

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



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

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



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

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

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

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

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

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Case study
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Conflict in the Nuba mountains drives famine and disease

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

In 2011, conflict erupted between militia

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

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

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

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

Uganda

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

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

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



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

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

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

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

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

Case study

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Southern Africa

Inga Thiemann

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

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

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

Namibia

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

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

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

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

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

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

Case study

Innovative mobile tuberculosis treatment reaches Namibia's nomadic San community

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



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

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

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



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

South Africa

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Zimbabwe

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

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

Health

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

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

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

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

West and Central Africa

Paige Jennings

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The UN Special Rapporteur on the right to

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

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

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

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

Forest-dwelling groups

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

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

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

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

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



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

Nomadic pastoralist groups

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

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

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

Côte d'Ivoire

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

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

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

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

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

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

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

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

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

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

Health

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

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

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

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

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

Mali

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

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

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

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

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

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

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

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

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

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

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

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

Health

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

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

Nigeria

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

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

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



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

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

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

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

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



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

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

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

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

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

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

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

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

Boko Haram

In 2012 Boko Haram ('western education

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

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

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

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

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

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

The Haratines make up between 30 and 40

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

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

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



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

are thought to be Haratines.

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

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

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

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

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

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

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

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

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

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

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

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

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



Central Africa

Burundi

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

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

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

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

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

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

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

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

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

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

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

Central African Republic

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

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

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

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

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

Health

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

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

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

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

Democratic Republic of Congo

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

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

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

Case study

Community health care succeeds for Batwa

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

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

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

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

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

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



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

higher rates of disease and malnutrition than their neighbours.

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

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

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

Case study continued

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

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

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

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

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

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

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

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

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

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

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

Upsurge in conflict

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

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

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

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

Ugandan governments, although both reject these allegations.

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

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

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