State of the World's Minorities and Indigenous Peoples 2013 Report – caste related extracts:

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Front cover Photo: A Dalit woman who works as a Community Public Health Promoter in Nepal. *Jane Beesley/Oxfam GB.*

In India, health workers refuse to visit a Dalit village because of untouchability practices. (pg.9)

In a village in Gujarat, India, most of the Dalits seeking health services have to wait longer for their turn because the dominant caste people are given priority. Only where the doctor is also a Dalit are they given equal priority in appointments. Health workers rarely visit the Dalit quarters of the village. In the health care centre, Dalits do not sit on the benches provided and they drink water from separate vessels kept for them. 'Untouchability' is widely practised in the delivery of health services.[2] Across India, these realities have meant that Dalits have disproportionately high rates of mortality and diseases compared with most of their fellow citizens. (pg. 13)

Picture pg. 13 of Dalit child receiving a health exam

These trends are evident in some statistics regarding the health MDGs. In India, child malnutrition is about 14–20 per cent higher for Scheduled Castes and Scheduled Tribes and has been declining at a slower rate than for the rest of the population over the MDGs period. (pg. 14)

Both direct and indirect discrimination can be compounding factors: in India, for example, although only about 1 per cent of disabled persons receive help from the government for education the percentage of beneficiaries among Dalits and Scheduled Tribes is about half that of the dominant caste group. (pg. 17)

(On Somalia) 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. (pg. 61)

Picture pg. 132 Dalit woman in Bangladesh

India Country Section

In May, India faced its Universal Periodic Review (UPR) by members of the UN

Human Rights Council. In September, the Council made a series of recommendations to India to improve its human rights record on issues including torture in police custody; repealing the Armed Forces Special Powers Act; religious freedom; and the rights of minorities and Dalits.

Many international organizations campaigned for Dalit rights issues ahead of India's UPR. Dalits, who make up a little over 16 per cent of the population, suffer consistent and continuous grave human rights violations by members of higher castes and have virtually no access to justice. In December 2012, the brutal gang rape and killing of a girl in Delhi sparked a national outcry as hundreds of thousands of women took to the streets to mourn her death and protest against violations of women's rights in the country. MRG and its partner organizations receive reports of many similar incidents of gang rape on Dalit women that go unreported and unnoticed. Attempts by victims to seek justice are often very difficult, as they face further violations and attacks by the law enforcement authorities they complain to. (pg. 135) …

In India, discrepancies in health outcomes occur on the basis of region, gender and social group. Although there is a lack of health data for minority and indigenous groups, the wide discrepancies between regional provisions of services and health outcomes in India is telling. The majority of India's Scheduled Castes (SCs) and Scheduled Tribes (STs) live in rural areas, where there is worse health care provision and worse health outcomes than in urban areas. Similarly, health indicators for regions such as Uttar Pradesh and Nagaland, which have relatively large populations of SCs/STs, are consistently poorer than for other regions such as Goa.

Infant mortality rates are 25 per cent higher for SCs/STs than for non-SCs/STs, according to a 2007 study by the UNDP. More recent studies in Andhra Pradesh show that infant mortality rates among SCs are double the national average and maternal mortality rates are 50 per cent higher than average. According to a 2007 UNDP study, a higher number of SCs/STs have no access to public health services compared to other groups; furthermore, since 1990, in some regions, the number of people with access to health services had actually declined.

Problems with lack of health services are compounded by broader socio-economic problems faced by communities. Examples include malnutrition caused by poverty, and the inability to take time off work to travel to health facilities or see a health worker. It was calculated by UNDP that, in 2000, 23 per cent more SC children, and 27 per cent more ST children, were undernourished than their non-SC/ST counterparts nationwide…

Discrimination suffered by marginalized groups also affects their health. In 2012, for example, the AHRC reported that an Ahirwar Dalit community in Maregoan

village, Madhya Pradesh was being deprived access to water and food following their refusal to carry animal carcasses; the local shopkeeper had been intimidated into refusing to provide rations to the Ahirwar by the dominant caste, and the local water pump and communal water tank were fenced in. The AHRC similarly noted in 2012 that the dominant caste preventing access of Dalits, tribal and minority communities to government welfare schemes is a common practice in Madhya Pradesh, Uttar Pradesh, Bihar and Orissa.

This kind of discrimination and exclusion makes minority groups much more vulnerable to disease, and dramatically increases the risks of malnourishment. It also directly affects their ability to access treatment from health services. In 2000, Action Aid found that in 21 per cent of 555 villages sampled from 11 states in India, SCs were denied access to health centres. The same study found that 48 per cent of villages denied SCs access to public water or drinking places. A 2010 study by Navsarjan, a grassroots Dalit rights organization, and the Robert F. Kennedy Center for Justice and Human Rights, found that doctors in 10 per cent of villages would refuse to treat Dalit patients. A follow-up study in 2012 found that three times more Dalit children were unvaccinated against polio than non-Dalit children.

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Nepal Country Section

Caste-based, ethnic and religious discrimination continued to be reported. In October, Bhim Bahadur, a Dalit from Dailekh district, sustained severe injuries after having been attacked for touching the front door of a house belonging to a person of a dominant caste. Dalits experienced restrictions on their religious freedom; Hindu priests and villagers prevented Dalits from entering temple precincts and participating in Hindu festivals. Christian groups reported receiving threats from Hindu extremists; these were usually linked to extortion…

Although Nepal's 2012 demographic health survey did not provide data about inequalities across caste or ethnic groups, previous population surveys have indicated serious disparities between the health of minority populations and that of the population at large.[5] The life expectancy of a Hill Brahmin was 68 years, while for a Hill Dalit it was only 61 in 2009, according to UNDP. In 2001, UNDP found that upper-caste Brahmins and Newars live, on average, between 11 and 12 years longer than Dalits and Muslims.

Disadvantaged minority groups face difficulty in accessing health services in Nepal, due to geographical remoteness, social stigma, or refugee status.

Marginalized groups, including Dalits and indigenous Janajatis, face barriers to accessing family planning services due to their illiteracy (which may prevent them filling in required forms), poverty (which may prevent them from paying for services), or their low social status (as a result of discrimination on the part of health workers). The very distribution of health workers is, in the first place, highly unequal across regions…

A number of sources suggest that insecure access to food and water is especially pronounced for indigenous groups, especially in mountainous regions, as well as for Dalits in Nepal. As a result, disadvantaged minority groups are more vulnerable to disease and malnutrition.

Maternal mortality for Muslims, Terai Madhesi and Dalit groups is higher than for other social groups. These rates are linked to the comparative lack of access to pre- and post-natal care for marginalized groups.

The latest figures from Nepal's Demographic Health Survey, in showing sharp disparities in child mortality between the far-western and eastern regions, strongly suggest that these trends have continued to create health differences between ethnic groups. Similarly, under-five mortality rates among Dalits are higher than among any other group, and well above the national average (95 out of 1,000 Dalit children do not survive to their fifth birthday, while for Newar children the figure is 43).

Although a 2012 Samata Foundation study in Sapatri district found that health workers do not in general discriminate against low-caste members at the point of service delivery, there is believed to be more widespread discrimination in terms of access to information about health care that Dalits in Nepal have, as well as health workers requiring increased interest rates or fees for services.

Dalits also suffer discrimination in accessing water due to their untouchable status. The AHRC reported in 2012 an instance where the non-Dalit community in Koteli village, Dadeldhura district prevented the water from flowing to Dalit households. The affected villagers, particularly women, have to walk five hours to fetch water – back-breaking work that causes stress as well as physical problems, and takes time away from crop cultivation.

(pg. 139-140 Nepal country profile)

Japan Country Section

Despite Japan's public narrative of racial and cultural homogeneity, the country is home to several minorities. These include the Burakumin, descendants of outcastes during the Tokugawa period, Ainu and Okinawan indigenous peoples,

ethnic Korean and Chinese populations, and its 'newest' minorities *nikkeijin*, Latin Americans of Japanese descent who began to return to Japan in the late 1980s.

Case study by *Emily Hong*

The nuclear disaster highlights health hazards for the country's marginalized workers.

In November 2012, Anand Grover, the UN Special Rapporteur for health, made a trip to Japan to investigate the right to health in the context of the triple earthquake, tsunami and nuclear disaster that devastated the country in March 2011. His report highlighted the tremendous health risks for nuclear plant workers exposed to high levels of radiation. At a press conference, the Special Rapporteur said, 'I was distressed to learn that there is a practice of employing a large number of contract workers through a layer of sub-contractors'.

Both Amnesty International Switzerland and an investigative documentary produced by European television network Arte have claimed that many of these temporary workers are from Japan's most excluded minority – the Burakumin.

It is difficult to verify how many of the clean- up workers are Burakumin, but one Burakumin worker, temporarily employed at a nuclear plant in Hamaoka, speaks about his recruitment in the Arte documentary. 'The Burakumin, the Japanese Untouchables,' Yoshito Fujita says, 'when I arrived, I saw that there were many homeless people, like me, working. I realized then that this company recruits in the poorest areas.'

Kazuyuki Iwasa, the first Japanese worker to sue the government for radiation-related illness, 40 years ago – was a Burakumin. Photographer Kenji Higuchi, whose work documents the exploitation of nuclear plant workers, has highlighted Iwasa's case, which was rejected by the government. In a speech on the Fukushima 50, he spoke of Iwasa's tragic case and untimely death: 'Of course his origin had something to do with his job. In our social structure a discrimination creates another discrimination.'

The term 'Burakumin' refers not to a distinct ethnic group but to people living in *Buraku*, areas where many but not all residents are descendants of the outcastes of feudal society during the Edo period. They were given work, such as leatherwork and butchery, considered 'tainted' according to Buddhist and Shinto beliefs. Despite the formal abolition of the caste system in 1871 and special government measures in the 1970s to prevent third parties from searching Buraku ancestry, the Burakumin – who number between 1 and 3 million – remain one of the most excluded and disadvantaged communities in Japan.

Discriminatory attitudes towards Buraku remain deeply ingrained in Japanese society. According to the Buraku Liberation League (BLL), between 10 and 50 per cent of people surveyed in several prefectures do not want relatives to marry a person of Buraku origin and do not want to live in a school district which includes a Buraku area.

The BLL's survey of 12,000 Burakumin women has shown the continued effects of such discrimination on employment opportunities. Between 60 and 70 per cent of women surveyed work in irregular precarious jobs, a number 1.5 to 2 times higher than the average. In a 2012 report on minority women in Japan, the BLL claims that 'difficulty for Buraku women in obtaining stable jobs originates in their educational backgrounds, which leave them no choice but to take seasonal or irregular work'. Such structural discrimination leads some Burakumin to take jobs in some of the most 'dirty, dangerous, and difficult' industries, including the nuclear sector.

According to Yuki Tanaka, a Professor at Hiroshima City University, Japan's poor, including many Burakumin, have difficult buying into the national health insurance programme because of the high premiums.

A further issue is the practice of subcontracting, which causes lack of accountability. The Fukushima plant is no exception. Plant owner and spokesperson for TEPCO, Yoshigi Hitosugi, denied ultimate responsibility for the health and safety of temporary workers in an interview with Arte. According to Hitosugi: 'We currently employ three hundred people at the site of Fukushima through sub- contractors. In the end, we do not know who is involved or what conditions are proposed for the most dangerous tasks.'

The dearth of public information on workers' health and safety in the ongoing clean-up at Fukushima points to a larger problem – the persistence of intersecting forms of discrimination faced by Japan's most marginalized minorities.

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