SEARO/WPRO

SOUTH-EAST ASIAN AND WESTERN PACIFIC REGION

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Rectifying Historical and Contemporary Prejudices and Oppressions Undermining Global Health

Introduction

The World Health Organization's (WHO) Southeast Asia Region (SEARO) and West Pacific Region (WPRO) consists of 48 countries spread across Asia and the Pacific.[1] This diverse group of countries faces a wide variety of public health issues that stem from historical and contemporary prejudices and oppressions that undermine healthcare. Southeast Asia stands out as one of the most ethnically diverse regions globally, with over 100 ethnic groups who communicate in more than 1,000 distinct languages and dialects.[2] Similarly, the Western Pacific region is also an ethnically diverse region with many indigenous groups.[3]

The historical dynamics within these regions have given rise to persecution of certain ethnic communities by dominant and larger groups, leading to instances of ethnic violence and genocide. Such adversities have profound repercussions on the health of persecuted individuals, significantly impeding their access to essential healthcare services. Beyond ethnic tensions, some cultures within these regions harbor traditional prejudices against specific groups, particularly individuals with uncommon sexual orientations. This bias manifests in gender, sexual, and queer violence, posing additional barriers to healthcare access. The intertwined nature of these challenges underscores the urgent need for comprehensive approaches to address not only the physical but also the sociocultural determinants affecting health outcomes.

In delving deeper into the health landscape of the SEARO and WPRO regions, it is important to recognize the intersectionality of persecutions and their ramifications on public health. Examining the impact on persecuted populations and the impediments to healthcare access is vital for formulating targeted strategies to promote health equity and address the challenges faced by these communities.

Additionally, an exploration of the connection between traditional values and gender/sexual health will shed light on the specific modes of inequality affecting these regions. By dissecting these issues, we can pave the way for informed interventions that foster inclusivity and mitigate the barriers hindering optimal health outcomes in the SEARO and WPRO regions.

Ethnic Persecution and Health

Ethnic persecution, the targeting and abuse of victims by reason of the identity of the group, can be incredibly damaging to the physical and mental health of different ethnic populations.[4] Ethnic persecution is often associated with war and human rights abuse, leading to the injury and death of ethnic minority populations.[5] These minority populations often do not have access to the same healthcare facilities as other populations in their respective countries, leading to more fatalities within ethnic groups.[6] Persecution further forces ethnic groups to seek refuge in neighboring countries or become internally displaced within their own.[6] The journey to seek refuge is often arduous, leading to mental health issues like PTSD, depression, and suicidal ideation.[6] Refugee camps are often unsanitary and crowded, leading to the spread of communicable diseases.[6] A lack of education and awareness about nutrition and healthy practices may lead to the higher incidence of non-communicable disease as well.[6] The SEARO/WPRO region has several large groups of ethnic minorities that face persecution, leading to severe healthcare inequalities that have led to the rise in disease incidence, malnutrition, and mental health issues in these populations.

Case Study #1: Ethnic Persecution of the Rohingyas in Myanmar and Bangladesh

Considered the world's most persecuted minority, the Rohingyas are an ethnic minority from Myanmar who live in the country's Western Rakhine state.[7] The Rohingyas constitute a predominantly Muslim community residing in Myanmar, which is largely populated by Buddhists.[7] Originally from Bangladesh, the Rohingyas arrived in Myanmar during British colonization as migrant workers.[7] After Myanmar gained independence, the Rohingyas were denied citizenship and became a stateless nation.[7] Historically, Myanmar has led several campaigns to target and eliminate the Rohingyas from the country allowing the human rights abuses of rape, arbitrary arrests, and destruction of homes.[7] The biggest wave of persecution to date happened in August 2017, forcing the Rohingyas to flee Myanmar and seek refuge mainly in Bangladesh.[8] About half a million Rohingya people now are displaced from their homes and are facing a healthcare crisis in Myanmar and in other countries around Southeast Asia.[8] The spread of communicable diseases, lack of treatment to injuries, and other mental health concerns are affecting the Rohingyas both in Myanmar and the places they are seeking refuge across Asia.[9]

About 600,000 Rohingya continue to reside in Myanmar, with approximately 142,000 of them being displaced within the country.[10] The Rohingya people in Myanmar continue to lack basic needs, freedom of movement, access to basic services, and a pathway to citizenship, all of which severely affect their health.[11] The population is restricted to a certain area in the country that does not accommodate or acknowledge the severe poverty rate of over 78%.[12,13] Rohingyas in Myanmar live in crowded camps and slums that have limited sanitation and healthcare facilities which has led to the spread of communicable diseases such as tuberculosis, AIDS, and cholera.[14]

In a 2019 study that examined healthcare access in Myanmar, it was found that the Rakhine State—where almost all Rohingya reside—had the lowest doctor to population ratio in the country, with only 1 doctor per 1000 people.[13] The costly administrative process and lack of access to healthcare prevent the Rohingya from seeking quality care, making them more susceptible to communicable diseases and prone to complications from other common tropical diseases like dengue fever and malaria.[13] If Rohingyas want to seek more costly medical procedures, even childbirth, they need approval from local administrators.[6] Even if they do get approval, Rohingyas require male escorts and have to navigate security checkpoints, where extortion is common.[13] Rohingya instead have to turn to traditional medicine that may not be effective for more fatal diseases and illnesses.[12] Infant mortality and maternal mortality are already high, with 67.24 deaths per 1,000 births and 380 per 100,000 births respectively.[14] With medical approval and a 6 pm curfew, where leaving in emergencies is also prohibited, Rohingyas are susceptible to a greater risk of losing their infant or life during childbirth.[14] The persistent state of conflict in Myanmar, insufficient support, and targeted discrimination against the Rohingya community have severely hindered the accessibility and quality of healthcare services available to them in their home in Myanmar.

While most Rohingya, nearly one million, fled to Bangladesh to seek refuge and escape the horrid conditions in Myanmar, they continue to face severe healthcare inequality in Bangladesh.[15] Rohingya are forced to congregate in severely unsanitary refugee camps. According to the United Nations Refugee Agency (UNHCR), acute respiratory infections, fever of unexplained origin, and acute watery diarrhea are the most widely reported health conditions in Rohingya refugee camps in Bangladesh.[12]

Insufficient immunization rates, along with overcrowded housing, malnutrition, and insufficient access to clean water and sanitation facilities, have led to the emergence of disease outbreaks, especially dengue, with over 17,000 cases being reported in Rohingya refugee camps in 2022.[11,15] These risks are further amplified during the rainy season (around June - October), prompting various humanitarian organizations in Cox's Bazar—the biggest Rohingya refugee camp— to establish an extensive plan for.[12] While there have been advancements in providing reproductive and sexual healthcare in refugee settlements in Bangladesh, ensuring accessibility to these services is still a matter of concern.[12] More recently, the true lack of healthcare access to the Rohingya population in Bangladesh was made evident by the COVID-19 pandemic. A NIH report on the effects of COVID-19 on the Rohingya population in Bangladesh found that there were "clear discriminatory limitations" on access to hospital beds, oxygen supplies, intensive care capacities, and vaccinations.[16]

Not only are Rohingya subjected to higher rates of communicable diseases, but also non-communicable diseases (NCDs).[17] A survey conducted in the US on Rohingya refugees who have resettled from Myanmar reveals an increased occurrence of chronic illnesses such as diabetes, hypertension, and obesity.[17] Additionally, there is a significant presence of risk factors for NCDs evident in both urban and camp settings.[17] Unhealthy diets and the excessive consumption of tobacco were found to be the major cause of the high incidence of NCDs in the Rohingya population.[17] Education about nutrition, healthy diets, and the effects of smoking and tobacco must be provided to parallelly bring down the incidence of NCDs in Rohingya populations. Mental health is also a prevalent problem in the Rohingya community. According to the UNHCR, about 26% of Rohingya report that they "tried to avoid places, people, conversations or activities that reminded them of a [traumatic event] most or all of the time".[11]

Most Rohingya had to endure horrific conditions in Myanmar and the journey from Myanmar to Bangladesh walking for days in the heat and tropical conditions.[11] Furthermore, the same UNHCR report details that 19% of Rohingyas "felt unable to carry out essential activities for daily living."[11] In Myanmar, over 50% of Rohingyas reported suicidal ideation.[11] PTSD, depression, and suicidal ideation are incredibly high and must be considered by other governments and NGOs when providing humanitarian aid to Rohingyas.

Case Study #2: Ethnic Violence in Manipur, India and its Healthcare Consequences

In May 2023, conflict erupted in the state of Manipur, India, pitting the Meitei majority against the Kuki minority in a struggle for control over land and power in the state.[18] Manipur is a hilly state located in the northeastern part of India, lying to the east of Bangladesh and sharing its border with Myanmar.[18] Home to 3.3 million people, Manipur has been historically prone to conflicts due to the diverse ethnic groups that reside in the state, with more than half being Meiteis, and around 43% Kukis and Nagas, the predominant minority tribes.[18] The Meitei community is largely Hindu and primarily resides in Manipur's capital city of Imphal and its thriving valley, while the Kukis and Nagas, who are predominantly Christian, typically inhabit dispersed settlements throughout the hills of the state.[19] Tensions between the two groups have persisted due to competition for land and public positions, as rights activists claim that wealthy Meitei leaders are exploiting ethnic divides for their own political advantage.[19] Violence erupted in May of 2023 as the Meitei received tribal status, which granted Meiteis a form of affirmative action through guaranteed quotas of government jobs and college admissions.[20]

However, minority groups Kukis and Nagas were denied the same status, forcing them to riot and protest for equality.[20] Protests were soon met with violence as Meitei mobs sought to eliminate Kukis and Nagas, burning settlements and forcing 60,000 Kukis and Nagas from their homes.[18] Over 11,000 Kukis and Nagas have been living in temporary shelters in the neighboring states of Mizoram, Nagaland, and Assam and others have been internally displaced in Manipur.[21] Constant conflict has shut down hospitals and healthcare facilities in the Manipur hills where most Kuki and Naga reside.[22] Additionally, the lack of healthcare facilities in refugee camps, blockages to the capital city of Imphal, and blatant refusal to treat minority ethnic groups are accelerating the healthcare crisis in Manipur, India.[22]

The ethnic persecution of Kukis and Nagas has significantly decreased their access to healthcare services in Manipur. In Manipur, the healthcare system is heavily centralized in the capital city of Imphal.[23] Due to ethnic divisions, patients from areas outside of Imphal, especially those belonging to the Kuki-Naga community in the hills, are facing significant challenges in accessing medical facilities.[23] The state's two main government hospitals and prominent private hospitals are all situated in Imphal, which is primarily inhabited by Meiteis.[23] This leaves individuals from other communities struggling to obtain essential medical care.[23] Since the start of the conflict, blockades have been set up to prevent communities outside of Imphal from accessing those hospitals even more so than before.[22] Even hospitals and clinics in the Manipur hills are facing difficulties, as blockades have prevented the movement of key supplies and resources.[22] Humanitarian efforts by The Indian Express report a “physician specialist crisis” as specialists from Imphal who used to travel to the hills to work are no longer permitted to.[22] The Manipur hills only had 60 specialists and medical officers to begin with of which were 16 Meiteis who were forced to leave their jobs because of the conflict, leaving the Kukis and Nagas with limited healthcare access.[22]

Patients who received bullet injuries in the chest during the conflict have had to be airlifted to neighboring Indian states due to a lack of facilities for emergency surgical care. It is estimated that about 40% of staff in hospitals in the Manipur hills have been forced to leave their jobs.[26] Chronic disease management and simple general healthcare are largely unavailable to Kukis and Nagas due to ethnic persecution.

Nutrition and sanitation are also issues Kukis and Nagas are facing due to the conflict. Relief and refugee shelters in Manipur and neighboring states are congested and cramped with poor sanitation.[21] During the monsoon season, areas of poor sanitation become breeding grounds for vector-borne and communicable diseases such as dengue, malaria, and tuberculosis.[21] In a study conducted by the National Family Health Survey (NFHS), it was found that 32% of Manipur citizens had limited sanitation services of which 5% of households had no sanitation facility and used open spaces or fields.[24] The situation has only worsened after the conflict began.[25] Physicians working in or visiting the refugee camps have reported a distressing health situation, especially for those who are vulnerable.[25] The overcrowding and inadequate sanitation arrangements, such as storing water in large plastic tanks that are not properly disinfected, pose significant risks.[25] With insufficient wastewater drainage and the upcoming monsoon season, sanitation and drainage conditions are expected to deteriorate further.[25] These cramped and substandard living conditions heighten the likelihood of disease outbreaks.[25] While some displaced individuals have received shelter, their diet mainly consists of two meals of lentils and rice with limited vegetables or meat.[25] There is minimal support for young children, pregnant and lactating women, as well as the elderly; disruptions in antenatal care and routine immunization add to these challenges.[25]

Mental health has similarly been a challenge for Kukis and Nagas. People are grieving the loss of their family members, property, and livelihoods.[26] Additionally, living in overcrowded camps for three months has been emotionally challenging.[26] Children are traumatized by displacement and the loss of a parent or sibling.[27] Furthermore, the uncertainty about the future and about the ability to return home has added to stress and mental health issues.[27] According to the Regional Institute of Medical Sciences in India, about 1 in 8 people in the Kuki and Naga community in Manipur are dealing with mental health issues.[27] Training healthcare workers to treat mental health is essential to combat the accelerating mental health issues in the Kuki and Naga communities.[27] Barely any humanitarian effort, or even recognition, has been made to help affected communities in Manipur.[27] It is essential that international humanitarian organizations, NGOs, and the government work together to ensure that the healthcare of the Manipur people is protected amidst this ethnic violence. The Indian government should start by officially acknowledging the Manipur struggle, a step they have not taken yet. This could raise awareness about the situation and prompt international organizations and NGOs to provide assistance to those impacted in Manipur.

Case Study #3: Uyghur Ethnic Persecution and Healthcare Repercussions in China

The Uyghur people are a majority-Muslim Turkic-speaking ethnic group that reside in the Xinjiang Autonomous Region of China.[28] Almost 11 million Uyghur have lived in the region for centuries, but since 2017 have been actively persecuted against by the Chinese government.[29] NGOs like the United Nations and Humans Rights Watch have corroborated reports that show that the Chinese government is detaining millions of Uyghurs in detention camps with high surveillance, intensive forced labor, religious conversion, and forced sterilizations.[29] The Chinese government involuntarily imprisoned Uyghurs in "vocational education and training centers" to "re-educate" and make them "better equipped" for society.[29] Instead, massive human rights violations have been committed against the Uyghurs with the UN calling it an international crime and crimes against humanity.[28] Besides the human rights violations occurring in these camps, the living conditions are horrid, with men, women, and children packed in prison-like conditions with limited sanitation and torture with no medical facilities at all.[28] Stripped from their homes and subjected to these conditions, the Uyghur have been observed having elevated mental health issues as well.[30] These camps are actively hidden from the public and international eye by the Chinese government, who cite that any claims of the Uyghur ethnic persecution are false.[30] The Uyghur continue to face this treatment across the Xinjiang region today, with many escapees from camps being shot on-site.[30]

Uyghurs suffer horrific healthcare violations in the captivity of the Chinese government. A common occurrence in the Uyghur detention camps is organ examinations and forced blood tests.[32] An investigation by the China Tribunal revealed that Uyghur Muslim prisoners are commonly subjected to organ removal procedures such as the extraction of hearts, kidneys, livers, corneas, and even skin.[31] These organs are trafficked and then sold for money or in black markets.[32] It is estimated that approximately 60,000 to 100,000 Uyghur individuals lose their lives annually due to organ removal, followed by reports of cremation.[32] Additionally, blood tests are used to catalog DNA samples of Uyghur to track and hunt down any Uyghur that are not in the detention camps.[33]

Furthermore, there have been raised issues regarding widespread breaches of the right to achieve the highest possible level of health—such as limited autonomy in accepting non-consensual medical care, inadequate availability of clean water and sanitation, and insufficient access to safe food.[34] Due to forced labor and torture, the Uyghur are expected to stay up late hours and are often consequently subject to sleep deprivation.[35] Additionally, reports of the few escapees from the detention camps mention that chronic conditions or communicable disease was never treated for, leading to mass deaths on a weekly basis.[35]

Reproductive and sexual violence against women has been on the rise for the Uyghur people.[32] Forced measures are implemented outside of detention camps to prevent births, such as sterilization or abortion, with around 80% of Uyghur women who are able to bear children.[32] The Chinese government has implemented a policy restricting Uyghur Muslims to having only two children, while the rest of the population can have three.[32] Those who exceed this limit are detained in camps where Uyghur Muslim women face numerous violations of their healthcare rights, including instances of rape, STDs, forced intravenous injections, and coerced IUD insertions.[31] The birth rate of Uyghurs decreased by nearly 60% from 2015 to 2018, according to reports by the Associated Press.[31] In 2014, just over 200,000 IUDs were implanted in Xinjiang.[36] By 2018, the number had increased to nearly 330,000, an increase of more than 60 percent.[36] In addition, female detainees are given unidentified medications and injections that result in unpredictable bleeding and disruption of their menstrual cycles, barring some from ever having children.[37]

Through this ethnic persecution, Uyghur families are being separated and gradually losing their ethnic and cultural existence in Xinjiang.[38] The United States Embassy reported that over 60% of Uyghurs frequently experience feelings of disconnection, recurrent memories of traumatic events, and difficulty sleeping.[38]

Even if any Uyghur manages to escape, they are well aware of the hardships and challenges faced by their families, friends, and relatives in their home country.[38] Their own struggles have also impacted their ability to adjust to life abroad.[39] In numerous host countries, members of the Uyghur community choose to distance themselves and often struggle with feelings of depression and anxiety.[39] While the attention of the Uyghur struggle has been brought to international attention, most foreign governments and NGOs have not been able to take tangible action as the Chinese government continues to deny any accusations.[39] Furthermore, China persists in pursuing Uyghurs worldwide, forcing them to return home where they face persecution.[39] However, groups like the Uyghur Human Rights Project (UHRP) are on the rise and bringing awareness of the Uyghur struggle by exposing hidden operatives against the Uyghur people.[39] Bringing awareness to the Uyghur struggle can direct attention to the issue so that NGOs and foreign governments can aid the humanitarian crisis.

Gender, Sexual, and Queer Violence

Cultures of gender-based violence devalue women, girls, LGBTQ/gender non-conforming individuals and promote aggressive masculinity, transphobia, and homophobia.[40] Dominant identity-based cultures celebrate a rich history of cultures and traditions, but inflict harm by imposing traditional patriarchal gender norms and roles, creating barriers for women and LGBTQ individuals to be included in society.[40] This cultural dominance is especially prevalent in Southeast and Central Asian regions, where LGBTQ and gender based violence (GBV) is most prevalent.[40]

Those affected by gender-based violence frequently encounter barriers in accessing healthcare services, which can contribute to higher mortality rates among the more vulnerable populations.[40] GBV compels survivors to seek safety in foreign lands or become internally displaced within their own countries, further exacerbating their trauma.[40] The journey to escape such violence is fraught with peril, often leading to mental health challenges, including post-traumatic stress disorder (PTSD), depression, and thoughts of self-harm.[40]

Case Study #1: LGBTQ Violence in India

LGBTQ, intersex, and asexual people frequently experience violence directed toward their sexuality, gender identity, or gender expression.[40] In India, a country known for its rich cultural diversity and vibrant traditions, anti-LGBTQ prejudice is a prevalent concern that threatens the safety, well-being, and human rights of the LGBTQ community.[63] While India has made significant strides in recognizing LGBTQ rights through the decriminalization of same-sex relationships in 2018, the LGBTQ community continues to face a range of challenges, including discrimination, violence, and societal exclusion.[40] This case study explores the pervasive issue of LGBTQ violence in India, shedding light on the root causes, consequences, and the urgent need for comprehensive measures to address this crisis.

One of the biggest types of LGBTQ violence in India is honor killings. Honor killing is the murder of either an outsider or a member of a family by someone seeking to protect what they see as the dignity and honor of themselves or their family.[42] Honor killings are also called shame killings, as they aim to eradicate "shame" from the family name.[42] Honor killings are more common in areas where religion or societal hierarchies play a major role in perceived sense of self.[42] The honor is usually defined by the standards of the local community.[42]

A study comparing the ideologies and intentions behind mass killings found that shame and honor play important roles in both honor killings and anti-LGBTQ homicides, although their influence manifests differently across these two types of homicide.[43] Violations of religious tenets, protection of masculinity, and protection of honor are evidenced in both types of homicide.[43] In India, where Hinduism and societal hierarchies are structurally present in communal interactions, these honor killings are common when LGBTQ individuals come out to their families.[44]. Many LGBTQ individuals are frightened of their community's reactions to their identity.[43] Those who feel unsafe in their own community leave to join Hijras, which provide LGBTQ-identifying people a traveling community to belong to.[46] Hijras are officially recognized as a third gender throughout countries in the Indian subcontinent, being considered neither completely male nor female.[46] While Hijra communities provide a sense of belonging for LGBTQ-identifying people, they are often victims of hate crimes and are deeply stigmatized against, often being equated as traveling "freak shows" or sex workers.[46] In February 2020, a transgender hijra community in Bangalore was brutally attacked by a group of men.[46] The attackers physically assaulted and humiliated the hijra individuals.[46] This incident, one of many anti-LGBTQ violent acts, was barely reported by local news and sparked outrage in the transgender community.[62] There is significant underreporting of violence against transgender individuals.[62] They face difficulties in police stations, as officers often refuse to register cases.[63] Indian laws addressing rape only recognize women as victims and survivors, excluding trans people.[63] Additionally, the Transgender Persons (Protection of Rights) Act, 2019, is not stringent enough, with a mere two-year jail term and a fine for the rape of a transgender person.[66] In the absence of proper laws, transgender individuals are compelled to endure the trauma of violence.

To address LGBTQ violence in India, comprehensive measures and structural reforms are crucial. Legal protections must be enacted and strengthened to explicitly shield LGBTQ individuals from violence, harassment, and discrimination, with a focus on active enforcement. Nationwide awareness campaigns and LGBTQ-inclusive educational programs should challenge stereotypes, promote acceptance, and dispel misconceptions. Tailored crisis intervention and support services should provide assistance, counseling, and legal aid to LGBTQ victims. Collaboration with LGBTQ organizations, community leaders, and advocacy groups can foster tolerance, inclusivity, and acceptance, challenging harmful cultural norms. Healthcare access for LGBTQ individuals must be ensured without discrimination, addressing specific needs like mental health support and gender-affirming care. Establishing data collection and reporting mechanisms is vital for evidence-based policies. Supporting organizations offering legal aid and advocacy can hold perpetrators accountable. International collaboration with organizations like the World Health Organization can facilitate sharing best practices. Advocacy for policy reforms challenging societal hierarchies and engaging with cultural and religious leaders are essential for a more inclusive and accepting perspective within communities.

Case Study #2: Female Genital Mutilation in Indonesia

Female genital mutilation (FGM) refers to "all procedures involving partial or total removal of the female external genitalia or other injury to the female genital organs for non-medical reasons."[48] Over 200 million girls and women have undergone FGM in over 30 countries.[48] FGM is a violation of women's human rights and is condemned by many international treaties and conventions, as well as by national legislation in many countries.[48] Despite this, in regions where FGM persists, the practice aligns with tradition and societal norms, aiming to secure social acceptance and marital eligibility for girls while upholding family honor and status.[49] WHO professionals believe religious and cultural beliefs impact families' decision to undergo FGM.[49] While FGC predates Islam and is not practiced by the majority of Muslims worldwide, medical anthropologists have learned that a significant proportion of Muslims globally believe FGC to be an Islamic imperative or, at the very least, something not to be condemned.[49] Indonesia experiences especially high rates of female genital mutilation.[49] The two most common forms of FGM in Indonesia are Type I and Type IV.[48] Type I FGM involved the removal of the clitoral glands, and Type IV includes non-medical invasive procedures.[48] Among the Indonesian population, scientists found that eight out of ten families reported that their daughters underwent FGM, with this rate only increasing in more traditional populations.[48] Most female children undergo genital mutilation within 1-5 months after birth, and are often physically scarred by midwives in rural areas.[48] In Indonesia, FGC remains a complex issue and has become a social norm.[49] The practice is often euphemistically referred to as 'female circumcision' rather than 'genital cutting' or 'mutilation' to minimize its significance.[49]

Indonesia has struggled to enact anti-mutilation legislation due to pressures from Islamic communities. In 2006, the Ministry of Health banned female circumcision by medical professionals, but in 2008, the Indonesian Ulema Council (MUI) issued a religious edict supporting it as part of Sharia.[49] The fatwa (a ruling by a religious figure) emphasized adherence to Sharia principles and discouraged dangerous practices.[49] In 2010, the Council urged the Ministry to permit medical professionals to perform female circumcision, resulting in pro-FGM policy development.[49]

Though this regulation aimed to ensure safe procedures, it faced opposition and was eventually repealed in February 2014.[49] Despite the repeal, there are no sanctions for those continuing female circumcision practices.[49] Critics have argued that this 2014 regulation is a step backwards rather than forward because it still allows for the practice of FGC to be continued without any state intervention and facilitation.[50] This lack of clear government action towards female genital mutilation has resulted in an increase of FGC rates in the country.[50] In 2016, UNICEF released a report which found that 49% of Indonesian girls under the age of 11 had undergone FGC.[50] This places Indonesia as one of the leading countries in FGC rates.

FGM is a controversial problem in Indonesia due to its ties to Islamic belief. The adoption of anti FGC legislation will have to be approached carefully. Medical anthropologists recommend using cultural humility in decision-making.[70] Legislation should be developed with a nuanced understanding of the cultural contexts in which FGC is practiced. The National Ulemas Council supported eliminating female circumcision in stages.[65] Recognizing the functionalism of the FGC ritual, they advocate for a non-invasive form of this practice.[49]. Public health professionals also advocate for increased awareness of FGC tolerance in Indonesian communities.[65] Currently, public awareness of this practice is low.[65] The subject is not discussed in schools and rarely in the media.[65] By increasing health literacy surrounding FGC and Islamic belief, health policymakers believe we can directly tackle the root cause behind female genital mutilation.[63] Lastly, it is also important to provide healthcare to victims of FGC. Outside of religious values, the practice has "no health benefits for girls and women and causes severe bleeding and problems urinating, and later cysts, infections, as well as complications in childbirth and increased risk of newborn deaths."[50]

Additionally, FGC entails acute physical trauma, carrying potential risks for both immediate and long-term complications, as well as mental health issues.[54] Physical injuries pose a potential risk for post-injury mental health problems; for instance, pain following traumatic injury has been associated with depressive symptoms in children and adolescents.[52] It is imperative to offer comprehensive mental health support and education to address these issues.

Case Study #3: Violence against Women in Bangladesh

Violence against women (VAW) represents a global public health challenge. Approximately one in three women experience either intimate or non-intimate partner violence at some point in their lives.[56] VAW encompasses various forms, including physical, mental, sexual, and economic violence.[56] Addressing this issue in the Southeast Asia region is paramount as it ranks second among the six WHO regions for lifetime intimate partner violence.[71] However, due to factors such as fear, financial vulnerability, and associated stigma, instances of VAW are often underreported, and prevalence estimates may not accurately reflect the true extent of the problem.[57]

Physical and sexual violence are the most commonly reported acts of violence against women in Bangladesh.[59] In Southeast Asia, 33% of partnered women aged 15-49 will experience lifetime physical and/or sexual violence from a current or former partner, with 17% enduring such violence in the past 12 months.[60] Women can experience sexual violence through acts including sexual and street harassment, limited access to hygiene products, forced marriages, digital harassment, cyber violence, marital rape, and the absence of accessible justice and survivor-centered support systems.[58]

75 percent of women have experienced sexual harassment.[60] Many of these victims experience legal barriers that deny justice to sexual assault survivors.[61] A study on rape laws in six South Asian countries reveals significant shortcomings, as legal frameworks effectively deny justice to survivors due to protection gaps.[58] Barriers to accessing justice include limited definitions of sexual violence, the failure to universally criminalize marital rape, and discriminatory evidence requirements.[61] Six Southeast Asian countries, namely Bangladesh, Bhutan, Nepal, Maldives, and Sri Lanka, allow the introduction of evidence on the past sexual history of rape victims, exacerbating challenges in the pursuit of justice for survivors of sexual violence.[60] Countries with built in social systems, such as Bangladesh, also pose a challenge in achieving sexual justice.[60] The intersectionality of gender, class, and caste in the case of gender-based violence against women and girls often remains hidden.[59]

Gender based violence creates stressors that negatively impact female mental health.[54] In Bangladesh, patriarchal norms lead to discriminatory attitudes favoring male offspring.[72] The birth of a boy is celebrated even in impoverished families, often leading to financial strain for elaborate celebrations.[72] In contrast, the arrival of a girl is unwelcome, with instances of extreme measures like sex-selective abortions in parts of Bangladesh and India.[59] In Southeast Asia, cultural norms perpetuate the social and economic subordination of women. Young unmarried girls and women often face severe psychological stress from violent behaviors, including wife-beating, murder, kidnapping, rape, assault, and injuries caused by acid.[56] Domestic quarrels, particularly over dowry payments, are common triggers for violence.[56] Additionally, women and children from the region are trafficked into prostitution, forced marriages, and bonded labor.[57] Factors such as illiteracy, political dynamics, feudal and tribal cultures, misinterpretation of religious principles, and the low societal status of girls contribute to and sustain sexual exploitation.[56]

Victims of trafficking endure violence, rape, and torture from employers, brothel owners, and even law enforcement agents, maintaining a cycle of sexual servitude through coercion, abuse, blackmail, deprivation, isolation, and threats.[57] Customs and traditions are often invoked to justify such violence.[55] Across various regions of India, a meta-analysis of 13 epidemiological studies indicated an overall prevalence rate of mental disorders in women at 64.8 per 1000, with higher rates for neuroses, affective disorders, and organic psychoses compared to men.[59] Similarly, surveys in Nepal and Bangladesh reported higher psychiatric morbidity among women, with sex ratios of 2.8:1 and 1.1:1 in Nepal's health post and district hospital, and a 2:1 sex ratio for mental disorders and 3:1 for suicide in Bangladesh.[56] There is a strong positive correlation between violence against women and mental health of women in violent regions of Southeast Asia.[64] The tendency of women to internalize pain and stress, coupled with their diminished status and limited control over their surroundings, makes them more susceptible to experiencing depression when faced with stress.[59]

Gender-based violence can be tackled through a unified approach against sexual and physical violence. Francesca Borgonovi tells us that “the work is on women and protecting victims but we need to make sure that boys do not escalate and adopt or normalize behaviors that allow them to perpetrate violence.”[61] Gender Activists advocate for increased sexual and physical health / violence education in Southeast Asian communities in order to deconstruct toxic societal understandings of masculinity and mobilize men to become gender equality advocates.[61]

By also pushing for an increase in women's political and economic representation, lawmakers can directly address VAW and garner community support to tackle gender based violence.[61] Gender Activists also urge South Asian governments to take comprehensive action in addressing sexual violence and discrimination against women and girls by addressing legal protection gaps, enhancing police responses, ensuring survivor-friendly medical examinations, improving prosecution procedures, and implementing holistic interventions for better access to justice.[60] In Bangladesh, gender organizations are already collaborating with partners to tackle the intersecting barriers to justice faced by survivors from marginalized communities.[64] These organizations have made significant progress in reducing acid based violence and caste based discrimination among women in Bangladesh.

Conclusion

The SEARO region has deeply rooted systems aimed to build oppression and prejudice against vulnerable communities. These systems have greatly impacted global health through persecution, violence, and hate. Through the case studies examining the Rohingyas, Kukis & Nagas, and Uyghurs, it is clear that ethnic persecution can have a damaging impact on health. Furthermore, gender, sexual, and queer violence in India, Indonesia, and Bangladesh have seen to be severely damaging on healthcare equity and access. In order to ensure that civilians are able to address their health concerns, initiatives to rebuild trust, health quality, and health equity must be enacted throughout the region.

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