HEALTH OF THE INDIGENOUS PEOPLES OF THE AMERICAS

EVALUATION OF HEALTH ACHIEVEMENTS WITHIN THE FRAMEWORK OF THE INTERNATIONAL DECADE OF THE WORLD'S INDIGENOUS PEOPLES

Health of the Indigenous Peoples of the Americas Initiative
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Foreword

Cultural diversity in the Americas is determined, a large extent, by the 45 to 50 million indigenous people belonging to more than 600 different ethnic groups in 24 countries. Therefore, analyses of health and living conditions should include consideration of the multi-ethnic character of the region and the potentiality that indigenous peoples show in their social organization, political proposals and wealth of their ancestral wisdom.

Despite the progress experienced in the region in the reduction of the burden of disease and death, the disparity in the health indicators among indigenous peoples and other vulnerable populations, is alarming. Illiteracy; unemployment; lack of land and territory; high morbidity and mortality from avoidable causes; and limitations in the access and utilization of basic health services, education, housing and other factors, are problems that affect the majority of the indigenous communities and influence their quality of life and health.

In order to achieve equity, the Pan American Health Organization (PAHO) has implemented systematic actions with regard to indigenous health in compliance with Resolutions CD37.R5 (1993), CD40.R6 (1997) and CD47.R.18 (2006).

PAHO`s technical cooperation and the actions of the Member Countries are based on the principles of the Health of the Indigenous Peoples Initiative, which demands the permanent involvement of the indigenous peoples themselves and the recognition and respect of their ancestral wisdom.

An adequate analysis of the progress and challenges that still persist in the health care of indigenous peoples is necessary for the development or reorientation of the efforts under way. In this regard, we are pleased to present this document which collects results from an evaluation of the achievements in health in 19 countries under the framework of the International Decade of the Indigenous Peoples of the World.

PAHO's renewed efforts to consolidate the Primary Health Care Strategy in the Americas, the priority granted to the processes aimed at compliance with the Millennium Development Goals (MDGs), together with the need for framing the analysis and addressing the health of the indigenous peoples, are favorable spaces to move forward with the pending compromise to achieve equity in the region.

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Introduction

The International Decade of the World's Indigenous Peoples (1995-2004) was proclaimed by the General Assembly of the United Nations Resolution 48/163 (1993) with the objective of strengthening international cooperation to contribute to the solutions of the problems that affect Indigenous Peoples in areas, of human rights, environment, development, education and health. The Pan American Health Organization (PAHO) and the Member States, in fulfillment of Resolutions CD37.R5 (1993) and CD40.R6 (1997) *(Annex 1)* and within the framework of the principles and guidelines of the Health of Indigenous Peoples Initiative, have given priority to the indigenous peoples´ health in the Americas.

In order to evaluate achievements over ten years of work, PAHO elaborated, at the beginning of 2004, an instrument *(Annex 2)* that facilitated the updating of the demographic and epidemiologic data. In addition, PAHO created a strategic analysis of the national processes and the systematization of the information in the following areas:

1) international agreements and local policies;
2) strategic alliances and networks of inter-institutional and inter-sector collaboration;
3) primary health care and inter-culturality; and
4) information, analysis, monitoring and management.

The evaluation instrument was sent to the 24 countries of the Americas that have indigenous populations: Argentina, Belize, Canada, Bolivia, Brazil, Colombia, Costa Rica, Dominica, Chile, Ecuador, El Salvador, the United States, Guatemala, Guyana, French Guyana, Honduras, Mexico, Nicaragua, Panama, Paraguay, Peru, Suriname, Saint Vincent, Venezuela. Out of 24 countries, 19 (or 79.16%) have responded.

Results from the evaluation highlight what has been done over the last decade to tackle health issues in indigenous communities at regional and national level. The experiences accumulated by PAHO have served as a basis for evaluating the achievements and challenges and these results include epidemiological data which summarizes the inequities that affect indigenous populations.

This document synthesizes the results of the evaluation of the regional meeting "Health of Indigenous Peoples of the Americas: Achievements and Future Guidelines" held in Managua, Nicaragua December 6th to 8th, 2004 *(Annex 3)*.These results are particularly relevant when added to the joint processes aimed at the fulfillment of the Millennium Development Goals. In fact, the "Managua Declaration" challenges the international community to join efforts in the construction of healthier, more equitable and stronger societies *(Annex 4)*.

Analysis of the results of the evaluation

When analyzing the International Decade of the World's Indigenous Peoples, it can argued that the achievements are minimal and that serious problems remain. However, it is also important to note that there are some areas that show signs of improvement. It is these areas that PAHO sought to evaluate in 2004 with the idea that it is not productive to emphasis what has not been achieved or who is responsible for the lack of progress. Yet, it may be necessary at some point to allocate responsibility in order to determine effective guidelines and to move forward. Evaluations like this one are particularly useful in this regard.

Several professionals participated in this evaluation with the common goal of improving indigenous health. They were motivated by a belief in the need for further knowledge of the experiences of indigenous peoples and the principles of PAHO in the area of indigenous health.

The Health of the Indigenous Peoples Initiative was launched in 1992 in response to what PAHO and the Member Countries considered a pressing need to support the health and living standards of indigenous peoples. Added to this were the legacy of exclusion, invisibility, and the denial of basic human rights to indigenous communities throughout the Americas. It was the five hundred year anniversary of the arrival of Europeans which coincided with the declaration of the International Decade of the World`s Indigenous Peoples that provided the context for this Initiative. The vigorous and renewed indigenous presence on the continental scene in combination with the principles of the Health of Indigenous Peoples Initiative from PAHO continue to be important driving forces in the promotion of indigenous health. (Chart 1).

A holistic concept of health from an indigenous perspective dates back centuries and includes conceptions of life; the right to self-determination; the right to health; and the systematic participation within the legal, political and social framework of the international community. Furthermore, respect, the revitalizing of indigenous cultures and the revitalizing of indigenous cultures and reciprocity in relations are also important.

Ten years have passed since the signing of the Declaration. However, the Declaration did not change the mentalities, attitudes or inequities that have persisted throughout the centuries, and some governments have responded with greater sensitivity than others. PAHO itself has had difficulty trying to include these new approaches in its concepts of health care.

It has been challenging for many countries to not only accept the fact that indigenous peoples have different perspectives, priorities, and outlooks on life, but to engage in a proper dialogue with them on equal footing. The United Nations and the Millennium Development Goals have provided an opportunity to start this dialogue and to rejuvenate the Primary Health Care Strategy.

Chart 1. Principles

- An Integrated approach to health;
- An individual's right to self-determination;
- The right of Indigenous Peoples to participate fully in the social and political process;
- Respect and revitalization of indigenous cultures;
- Reciprocity in relationships.

As a result, by mid 2004, a evaluation methodology was developed in order to evaluate these processes and was sent to the 24 countries with indigenous population. Out of these 24 countries, 19 or 79.16% provided the requested information. Three countries or 15.78% of those that answered had a participative process and sub national meetings directly with indigenous participation. Some of the participants recognized that many indigenous communities did not have access to information and did not know PAHO`s resolutions.

The statistics presented here illustrate only a sample of the content in each national evaluation. However, before indicating the main results, it is advisable to present the following points in order to better understand what is being analyzed.

- First of all, it is important to keep in mind that we are dealing with a very diverse geographic area with communities located in different countries.

Although there are many similarities in the perceptions of indigenous peoples (specifically their close relation with Mother Nature and the burden of exclusion, the situation is not the same in a country with a majority of indigenous peoples than in another country with only a minority. These concepts should be taken into consideration and the available statistics, as a result, must be used cautiously.

- Those statistics that are available comment on the way nations were created by their founders, the arbitrary division of peoples and the excluding model of development. It is now possible to think of two different models: those with indigenous minorities and institutions that are consolidated and those with indigenous majorities and weak institutions because no model has prevailed. The representation of all peoples and their national states is what is in jeopardy.

There are considerable tensions between globalizing tendencies on the one hand and local and regional tendencies on the other. This does not mean however, that they are in opposition to each other. Everyone is part of the global market and information surpasses borders. However, because not everyone participates in globalization in an equal way and because resources are scarce, property tends to be viewed as a local strength with protection from indiscriminate aggression. In order to understand this context, it is necessary to be aware of the conflicts that arise over land issues and natural resources.

With these considerations in mind, this analysis starts with a reflection on the geographic location of Indigenous Peoples and a diagnosis of the inequities that affect them. Next, the analysis examines the indigenous presence in agreements, laws, alliances and networks, as well as information and management and the experiences that have surpassed these inequities. It is only within this context that a suitable approach to evaluating achievements or successes and failures is possible.

Indigenous peoples have a strong presence throughout the American continent and are present, to an extent, in almost every country. Even in Brazil with an official indigenous population of only 0.25%, the report notes "Indigenous Peoples are present in all Brazilian states, except in Piaui and Rio Grande del Norte living in 579 indigenous lands, occupying almost 12% of the national territory."

The indigenous presence stems from two fundamental factors: first, they have a strong connection to the earth by which, as Suriname indicates "the migration of population is a very important factor, and mobility per se is not a problem for Indigenous Peoples". Displacement from armed conflicts, exclusion and poverty, are the other factors. Many natives that populate cities and valleys, plantations and markets and cross national and international territories without defined borders and even virtual communities. Chile, for example, indicates that "Indigenous Peoples are located in rural and urban zones. The Metropolitan Region concentrates 23.7 of the total indigenous population of the country".

In general, the indigenous presence is a positive one. Their perceptions of life, health, nature and spirits and their sense of collectivity can teach us many things. The fact that there are a number of indigenous peoples throughout the continent can possibly make us closer and more inclined to mutual learning. However, this does not invalidate the obvious reality of ancestral territories and indigenous regions such as the region of Kuna Yala of Panama. We have to work with what García Canclini labels the "maps of sense," with peoples who have their roots in specific places but are also mobile.

The origin and settlement of Indigenous Peoples is well documented and it is in these records that we find the deepest and most brutal inequities in poverty and misery as well as the deficiency of utilities, the highest rates of maternal-child mortality, undernourishment and infectious diseases.

If we take into consideration the Millennium Development Goals (proposed by countries of the United Nations to diminish inequity) we get a complete diagnosis *(Chart 2.)*

It is obvious that there are differences in each one of the regions and many of the countries emphasized have tried to deal with the problems associated with Indigenous Peoples, governments and the international community. An important question remains:

How have they done it?

Of those countries included in the evaluation, 100% or 19 claim to have some type of legal guidelines in place for their relationship with Indigenous Peoples. In terms of international agreements, 68.42% or 13 of the countries that provided responses ratified Agreement 169 of the International Labor Organization, which officially recognizes the existence of Indigenous Peoples and their rights. In addition, 31.57% or 6 countries reported their accordance with other agreements such as the International Convention on Elimination of all forms of Racial Discrimination (1966) and the Agreement on Biological Diversity, (1992). In terms of national legal frameworks, 68.42% or 13 of the countries that responded included in their constitutional principles the recognition of multiethnic, multilingual and multicultural character of their population.

Further, these same countries have national policies dealing with indigenous themes. Indigenous health care is dealt with by 94.73% or 18 of the countries that responded. This priority is also reflected in the existence of technical units responsible for the health of Indigenous Peoples in Health Ministries in 110% or 19 of the reporting countries. Additionally, 63.15% or 12 countries have similar technical units in other ministries and 3 countries reported instances where indigenous development was at the level of the Presidency of the Republic.

The numbers that speak to the presence of agreement of a national, inter-instutional, inter-sectorial and multi-country character are very encouraging. These percentages vary between 100% or 19 countries and 84.21% or 16 countries.

Among the many subjects discussed are indigenous women, children, adolescents and other problems such as HIV/AIDS, lack of water and sanitation, land demarcation, extension of health care and effectiveness of human rights policies. Also noteworthy is the large percentage (94.73% or 18 countries) of indigenous, national, and local organizations that include health in their political agendas.

The conceptual and methodological development of the intercultural approach starts with the concrete experiences of Member Countries and has been an important reference in the improvement of health services in zones with large indigenous populations. This takes into consideration their ways of life and ancestral wisdom.

A large percentage of countries (78.94% or 15 countries) have given specific consideration to the legal frameworks that promote the incorporation of indigenous perspectives, therapies and medicines in the national health system. Several countries deal with the issue in isolation, while others use the framework of inter-culturality for specific projects.

Chart 2. Millennium Development Goals: Inequity

Objective	Country	Natives	Non indigenous
Poverty	Canada	34%	16%
	Chile	32,2%	20,1%
Illiteracy	Bolivia	19,1%	4,51%
Equity between genders and autonomy of women.	Guatemala	Illiteracy among indigenous women between 50% and 90% and only 43% finishes the primary level, 5.8% the average education and 1% the higher education.	
Infant mortality.	Panama	84 x 1000 nv	17 x 1000 nv
Maternal mortality.	Honduras	255 x 100.000 nv	147 x 100.000 nv
Fight against malaria, HIV/AIDS and other diseases.	Nicaragua	90% of malaria cases by falciparum are concentrated in 24 municipalities with indigenous population.	
Environmental Sustainability .	El Salvador	95% of the superficial water sources are contaminated. Undernourishment in indigenous children as compared with 20% in national scope.	
The sponsorship of a world-wide association for development.	The presence of similar problems among Indigenous Peoples, particularly in those living in the border zones (Ex. Similar epidemiologic profiles, presence of refugees, changes in the dynamics of life, acculturation, loss of territories, etc.) It demands an urgent coordinated work among the countries of the Region and the development and/or the application in international and sub regional agreements.		

Source: Data provided by countries in national evaluations. PAHO, 2004.

The sheer number of projects a country adopts demonstrates donor interest in the area. Several respondents (89.47% or 17 countries) report programs for training individuals in human technical capacity to tackle the problems of Indigenous Peoples.

The evaluation does present some problems however. The percentage of countries that refer specifically to programs of research is low at 31.57% or 6 countries. The lowest percentage corresponds to scholarships and economic aid given to indigenous peoples to study. Only 26.31% or 5 countries of the 19 examined reported scholarships for university studies and 2 of them included provisions for students to study medicine in Cuba.

Another problem evident from the evaluation is the low degree of integration of indigenous therapists into official health programs (52.63% or 10 countries)

Information systems and the monitoring and evaluation of the health of Indigenous Peoples reported some advances but remained low at 52.63% or 10 countries. The theme of indigenous health did not seem to garner the attention of universities or corresponding ministries and indigenous organizations (42.10% or 8 countries mentioned the issue in periodic publications and 57.89% or 11 countries through electronic information).

The overall picture of the evaluation highlights several projects dedicated to indigenous health but there remains a serious lack of coordination. If we add what has been referred to as a "lack of intercultural education" the situation is made much worse by the low level of intercultural "social" policies in general.

There are several threats to the actions we perform. The mishandling of political and economic power, the increasing poverty , the lack of land, and the economic and political dependency of the indigenous population are some of the major problems emphasized throughout the evaluation. Although we must consider these shortcomings, we also have to consider the progress that has been made.

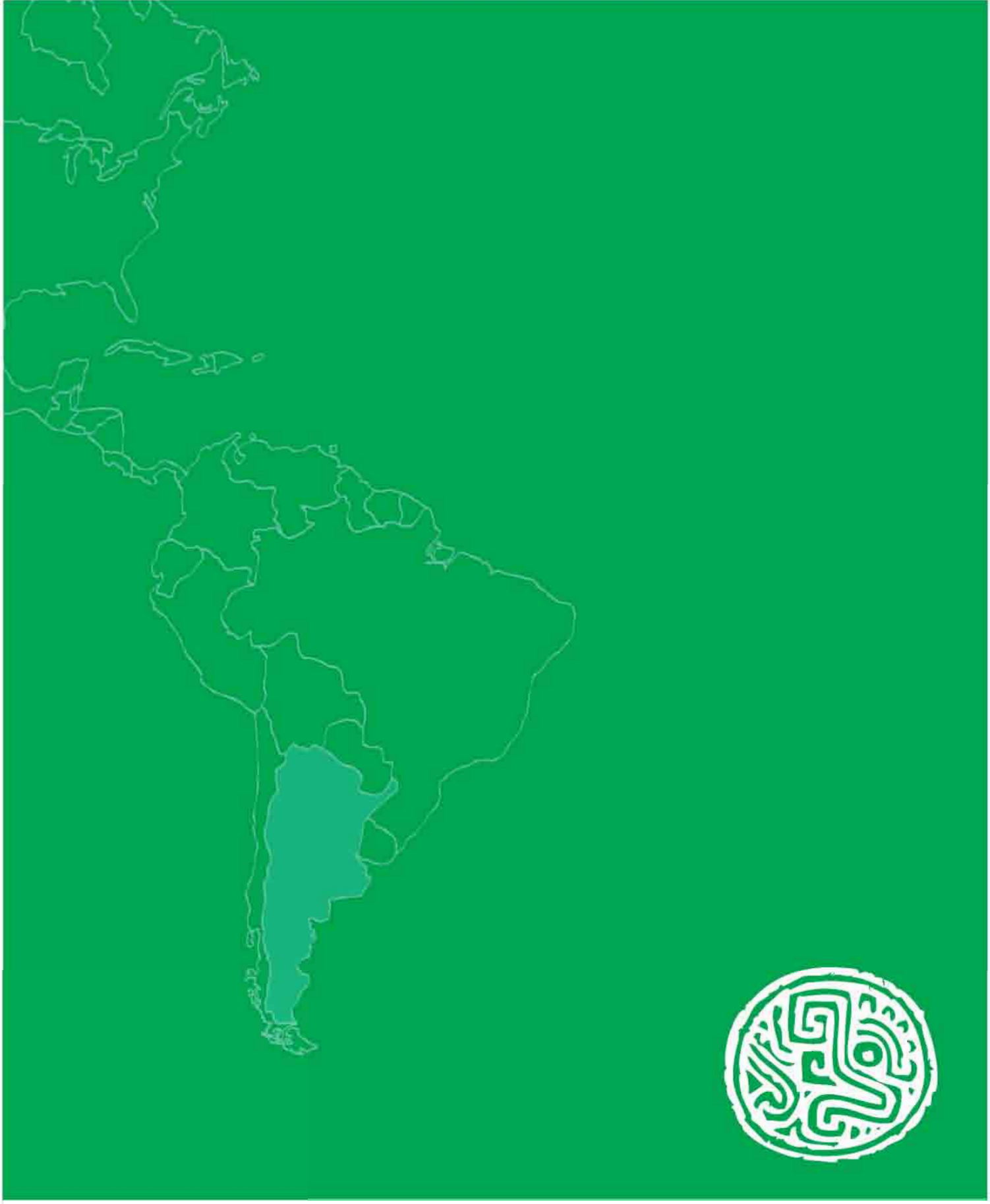
Among these advances we can consider the following:

> Indigenous Peoples are now more visible than they were before as demonstrated by agreements, covenants, constitutions; and public policies. There is no doubt that some of the experiences and innovative projects mentioned promote self-management of local governments. Further, some of these projects are directed by indigenous leaders and have helped reduce the high indexes of morbidity and mortality. Yet, if these results are not reflected in the statistics it is largely because of the problematic levels that these issues have as well as a lack of information and monitoring of actions.

> We believe that the degree of consciousness on the part of societies and of Indigenous Peoples regarding their own rights has to do not only with visibility on the part of an indigenous community nor with the number of projects executed in their territories and populations, but with the participation of all towns as part of multiple societies. In this sense, even if great advances have been achieved, the construction of true citizenship based on respect and recognition still has a long way to go.

> Further studies in these areas need to be undertaken by all of us. Discussions, workshops, and demonstrative experiences will help us make more precise and specific plans to advance the commitments of indigenous health. Only after this is done, will we be able to create more equitable and plural societies.

Results of the Evaluation by Countries



Argentina

1. International agreements and national policies

International Agreements	Legal frameworks		Technical units responsible for Health of Indigenous Peoples	
	National Constitution Policies	Health Policies	Governmental instances Ministry	Contact Information
Agreement 169 of the International Labor Organization (ILO). Agreement of Biological Diversity. Resolution CD37.R5/PAHO. Resolution CD40.R6/PAHO.	National Constitution **Art. 75, inc.17:** the Reform of The National Constitution of 1994 guarantees and it is recognizes the Ethnical and Cultural Pre-existence of Indigenous Peoples. **Article 75, inc.17:** "It corresponds to the Congress... to recognize the ethnic and cultural existence of Argentinean Indigenous Peoples, to guarantee the respect to their identity and the right to a bilingual and intercultural education; to recognize the legal person of their communities and possession and communitarian property of land that they traditionally occupy; and to regulate the provision of other land apt and sufficient for human development..." **23,302 law and Prescribed Decree 155/89:** Law 23,302 of Indigenous Policy and Support to the Native Communities creates the National Institute of Indigenous Affairs (INAI), and developed in its articles 18, 19, the 20 and 21 powers of authority for the accomplishment of health plans and environmental sanitation. **Law 24.071.** It adopts Agreement 169 of the ILO, updates the treaty, and explicitly recognizes for the first time Indigenous populations as "Towns". As of July of the 2000 Executive authority it deposited the Instrument of Adherence and the 3rd of July of the 2001 it became effective in Argentina. **Law 24.375.** Argentina ratifies its adherence to the Agreement of Biological Diversity that arises from the meeting in Rio de Janeiro in 1992. ***Reforms:*** in the Constitutions of the provinces of Buenos Aires, Chaco, Chubut, Jujuy, Formosa, the Pampas, Salta, Neuquén and Río Negro.	**1994.** Subprogram "Strengthening of Primary Health care in Indigenous Communities, revaluating its culture in areas affected by cholera". Health Ministry of the Nation. **1995.** Health Program with Indigenous Peoples. Health Ministry of the Nation. **2000.** Program of National Support of Humanitarian Actions for Indigenous Populations (ANAHI). Health Ministry of the Nation. **2004.** Health Program of Indigenous Peoples. Health Ministry of the Nation.	> Health Ministry of the Nation > Ministry of Public Health of Chaco > Ministry of Human Development of Formosa > Ministry of Social welfare of Jujuy > Ministry of Public Health of Misiones > Ministry Public Health of Salta IF. PRO. SA Tucumán > Pan American Health Organization	> Ms. Daniela Rosana Mele: to salud_indígena@msal.gov.ar > Dr Raul Pelizardi > Dr. Cristina Mirasou > Mrs. Mabel Pelo > Dr Enrique Deschutter > Dr. Catherine Comedi > Dr. Luis Eliseo Velasquez

2. Strategic alliances and inter institutional and inter-sectorial cooperation networks

Agreements of the Indigenous Health Program.	> Health Ministry of the Nation (MSN) with Provincial Ministries of Health (MSP). Ministerial resolution 1995-2004 for hiring indigenous sanitary agents, training of human resources, execution of provincial programs and local projects. > Health Ministry of the Nation (MSN) with Ministry of Labor and Social Security (MTSS). Agreement No. 422/95 and Resolutions of Ministry of Labor 1995 - 2004 for hiring indigenous health promoters.
Inter institutional/ inter sector projects of the Indigenous Health Program.	> **1996.** Workshops of Nutritional revaluation in the department of Susques, Jujuy with the Program Woman, Health and Development, MSN. > **1996.** Project for Recovery of Agro-alimentary System of the Susques Department, Jujuy, with Maternal-enfant Program, MSN > **1996.** Project Provision of Drinking Water in the Locality of Pasto Chico Susques Department, Jujuy with the department of Environmental Sanitation, MSN. > **2002.** Demonstrative project Lapacho I for the Improvement of the Environmental Conditions, Salta. PAHO/WHO. > **2004** onwards Safe water for the indigenous communities of Salta and Formosa with the Regional Project of Improvement of the Environmental Conditions for Indigenous Peoples, GTZ/CEPIS/PAHO. > **2002** onwards. Study of Social Evaluation of the Indigenous Population. Region NEA-NOA. Program of Integral Health PNUD-ARG 02/026.
Multi country Projects.	Institutional development of the Coordinator of Organizations and Indigenous Peoples of the Chaco Sudamericano/COPICHAS Bolivia, Argentina, Paraguay.
Inter institutional / inter sectorial fora.	> **1996.** Symposium: Indigenous Peoples and Health. Organized by the National Academy of Medicine and Argentinean Pediatric Society. > **1997.** Workshop: Native woman and Health. Organized by the Program Woman, Health and Development, MSN. > **2000.** Workshop on Formation and Agreement on Plans and Policies of Indigenous Development ". Organized by the Indigenous Association of the Argentine Republic. > **2000.** National meeting on Health for Indigenous Populations. Organized by MSN. > **2003.** Meeting for the Organization of the National Work Group. Regional project Improvement of the Environmental Conditions for Indigenous Peoples. Organized by MSN/GTZ/CEPIS/PAHO. > **2004.** Conference "Inter culturality for Fairness in Health". Organized by the Argentinean Society for Fairness in Health. > **2004.** National forum "Rights of Indigenous Peoples in Public Policy". Organized by the Ministry of Social Development of the Nation through Indigenous National Institute.
Indigenous organizations that include addressing health in their political agendas.	National Group of Aborigine Pastoral (ENDEPA), Indigenous Association of the Argentine Republic (AIRA), Association of Indigenous Communities (ACOIN), Center Kolla- Argentine Republic, Institute of the Native Chaqueño, Institute of Native Communities of Formosa (ICA), Indigenous Provincial Institute of Salta (the IPI), Advice of Native Communities of Jujuy (COAJ), Mapuche Coordinator of Neuquén, Direction of Guaraníes Affairs of Misiones, among others.
Networks	

3. Primary health care and inter culturality

Policies that promote the incorporation of indigenous perspectives, medicines and therapies in the National Health Programs.	> **1996.** Farming Social program and Regional Development Program of INTA, Jujuy > **1995-2004.** Health Program of Indigenous Peoples. It is a framework of health policies and its purpose is to improve the health conditions of different indigenous communities, using APS strategy as basic themes and articulated with sectorial and extra sectorial resources. Conceptually this Program understands that it is essential that the system recognizes and values cultural diversity, inter-relationships and local strategies in order to reach a greater acceptance and affect on the health of these communities.
Experiences of harmonization of indigenous and conventional health systems.	
Associations of indigenous therapists.	
Human Resources Training and development program (research and scholarships).	Academic courses and meetings: > Argentinean Society of Anthropological Medicine. Theme: anthropological medicine, shamanism, use of traditional medicine, interculturality and integral health. > Research Institute in Medical and Nutritional Anthropology. La Plata-Salta, Argentina.

4. Information, analysis, monitoring and management

Information on the demographic, socio-economic and epidemiologic profile of Indigenous Peoples.	The censuses on indigenous peoples in Argentina are vague. The 2001 National Population Census incorporated a question that was designed to detect the homes where at least one person declares to be descendant or belonging. The second phase (May-November 2004) a specific survey of a sample of homes that answered affirmatively. It is estimated that approximately 3% of the population is composed of natives.
Information systems, monitoring and health evaluation of Indigenous Peoples, which includes the ethnicity variable.	Health statistics in our country do not discriminate against ethnicity. The information from local health systems is derived from relevance of sanitary zones and the percentage of indigenous peoples.
Location Maps of Indigenous Peoples according to the political division of the country	see Attachment map. *(pag. 19)*
Characterization of Indigenous Peoples with respect to condition of life and health, social organization and maintenance and restoration of health.	Publication ANAHI. PEN-Health Ministry of Nation, Bs. As., 2000.
Periodic publications on the health of Indigenous Peoples.	Provincial Official Bulletin. Instructive Pre APS Round held quarterly.
Section on health of Indigenous Peoples in the electronic page on the Health Ministries, PAHO or other institutions (e-mail).	**Health Ministry and Environment of the Nation:** www.msal.gov.ar **Representation PAHO/OMS Argentina:** www.ops-oms.org.ar

Second part

1. What are the most relevant achievements in the Health care of Indigenous Peoples in the period 1995-2004?

> The Health Ministry of the Nation created in 1995 the National Health Program of Indigenous Peoples.
> The creation of provincial programs that focus on issues of indigenous health in six provinces and the respective transfer of national funds for their execution.
> The Incorporation of indigenous Sanitary Agents and extension of primary health care coverage promoting the accessibility to the basic benefits of the health system.
> Progressive training of Indigenous Sanitary Agents in the role of cultural facilitators to develop promotion tasks and protection of health and prevention and support for control of diseases.
> Mechanisms of jurisdictional monitoring of plans of action and technical assistance in the field in sanitary zones.
> Implementation of innovative projects technologically adequate for rendering basic water and sanitation services in coordination with governmental, non-governmental and indigenous organizations.
> Management of initiatives for the accomplishment of projects and local experiences with an active participation of the communities in coordination with bodies of international technical cooperation.

2. What are the priority problems in the Health care of Indigenous Peoples in the period 1995-2004?

> Fragmentation in the use of the human and financial resources assigned to sectorial and extra-sectorial plans and programs, and those belonging to the improvement of health conditions of Indigenous Peoples.
> The hospital focused characteristic of the system.
> Inequity in the access and use of health services: the socio economic level and the geographic accessibility considerably affect access.
> Work scheme that do not include/understand the knowledge and indigenous Cosmo vision in the interaction with health systems.

3. What are the aspects to consider in the insertion of health of Indigenous Peoples as a priority in the processes that the country is promoting in the renewal of the Strategy of Primary Care and in the fulfillment of the Millennium Development Goals?

> Recognition of the cultural diversity paradigm for the construction of an integral health with emphasis on the articulation between indigenous and western traditional medicine.
> Protection of the ecological biodiversity in territories of Indigenous Peoples, as natural resources are affected by development activities and projects of development that put in danger the health of the communities and the population in general.
> Mobilization of resources that promote bilingual education as a principle and coexistence as opposed to the ethnic, cultural and linguistic diversity, in an intercultural framework.
> Design of strategies that enable systematic and coordinated information gathering on the conditions of life and the situation of health.

Strategic analysis	
Strengths: particular characteristics of the country that would facilitate the actions for the improvement of the health of Indigenous Peoples.	**Weaknesses:** negative factors inside the country that make difficult improvement in the health of Indigenous Peoples.
> The existence of a Plan of National Health and provincial Plans of Health based on APS strategy. > The progressive development of initiatives that mobilize the self-management capacity of the communities and the concentration of efforts through local governments (provinces and municipalities).	> Inequity in the allocation of resources: no explicit criteria and thus, no specific indicators. > There is not intercultural training of human resources or postgraduate specializations. > Coexistence of perspectives: assistentialism versus self management, integration versus interculturality.
Opportunities: factors that are in context, and it is believed they will act in favor of actions for improvement of the health of Indigenous Peoples.	**Threats:** negative factors that can affect the implementation of actions for improvement of health of Indigenous Peoples.
> The implementation of the Complementary Survey of Indigenous Peoples ECPI, which will cover the need to have statistical data and will contribute to planning public policies and programs. > The integration of health areas with those of the environment and sustainable development. > The gradual building of strategic alliances to support the work of solutions for the improvement of the health conditions of Indigenous Peoples.	Pre existence of power and authority systems, complexity of the internal relations of the community, the community health relation, and interests on the theme.

Third part

Table 1. Population and Indigenous Peoples of Argentina (population in thousands of inhabitants)

National population	Indigenous population (estimated)	%	Peoples
36.260	1.100	3	25

Source: Census 2001. National institute of Statistic and Census. Republic of Argentina.

Table 2. Challenges, factors to consider and inequities

Challenges

Health and public health strategies must include an approach that structural takes into consideration the factors of risk and of insertion in the strengths of Indigenous Peoples.

Factors to consider

> **Location.**
Most indigenous communities are located in rural zones, some with difficult geographic access; distribution shows a high dispersion. Likewise, the internal migration process, entails displacement of families from their places of origin in favor of the cities in order to find life conditions which typically are not achieved.

> **Ethnic and cultural heterogeneity**
Argentina is a multiethnic and pluricultural country. There are 25 groups of Indigenous Peoples located in most of the Provinces. The greatest diversity of indigenous peoples are in Northwest: Wichi, Tufas, Chorotes, Ava Guarani, Tupi Guarani, Chane, Tapietes, Chulupies, Atacama, Ocloya, Omaguaca, Diaguitas Calchaquí, in the Provinces of Salta and Jujuy. In the Provinces of Chaco and Formosa there are: Wichi, Tufa, Pilaga, Mocovi; in the province of Missions: Mbya Guarani; in the Province of Santa Fe: Mocovi and Toba; in Entre Rios: Charruas; in the province of Tucumán: Diaguitas Calchaquí and Lules; in the province of San Juan and Mendoza: Huarpe; in Santiago del Estero: Mocovi and Tonicote; in Neuquén: Rio Negro and Chubut Mapuche; in Pampas: Ranquele-Mapuche; in Cordova Comechingones; in Santa Cruz: Mapuche, Tehuelche and in Tierra del Fuego: Onas.

Inequities

> **Poverty:** The indicators selected to evaluate social vulnerability are sufficient to demonstrate the indigenous population, can barely achieve the minimum level of basic needs.

> **Illiteracy:** They have a high illiteracy rate and low average levels of education. For the problems of access and educational coverage, those of "pedagogical relevance" should be added.

> **Unemployment:** The economic activities of Indigenous Peoples do not respond to employment criteria and t are limited to seasonal agricultural work, artisanal production and the insertion in temporary work plans subsidized by the state. In some cases there are also, actions directed to the production for self-consumption. Different combinations of these activities are part of subsistence strategies.

> **Utilities:** In general the provision of safe water is insufficient to cover the minimum necessities of families. Thus, madrejones, service reservoirs and dams are the alternatives. In communities where there are schools, water is collected in high tanks using rams or if they have electricity, pumps to elevate water from wells or perforations.

> **Infant mortality rate:** In general terms, neonatal mortality is higher than the post neonatal, although the rate of specific mortality has diminished.

> **Maternal mortality:** A clear predominance of direct obstetrical causes exists for maternal mortality, the situation is more serious if it is considered in Northwest and Northeast regions since the maternal age is lower and fecundity is higher than the national average.

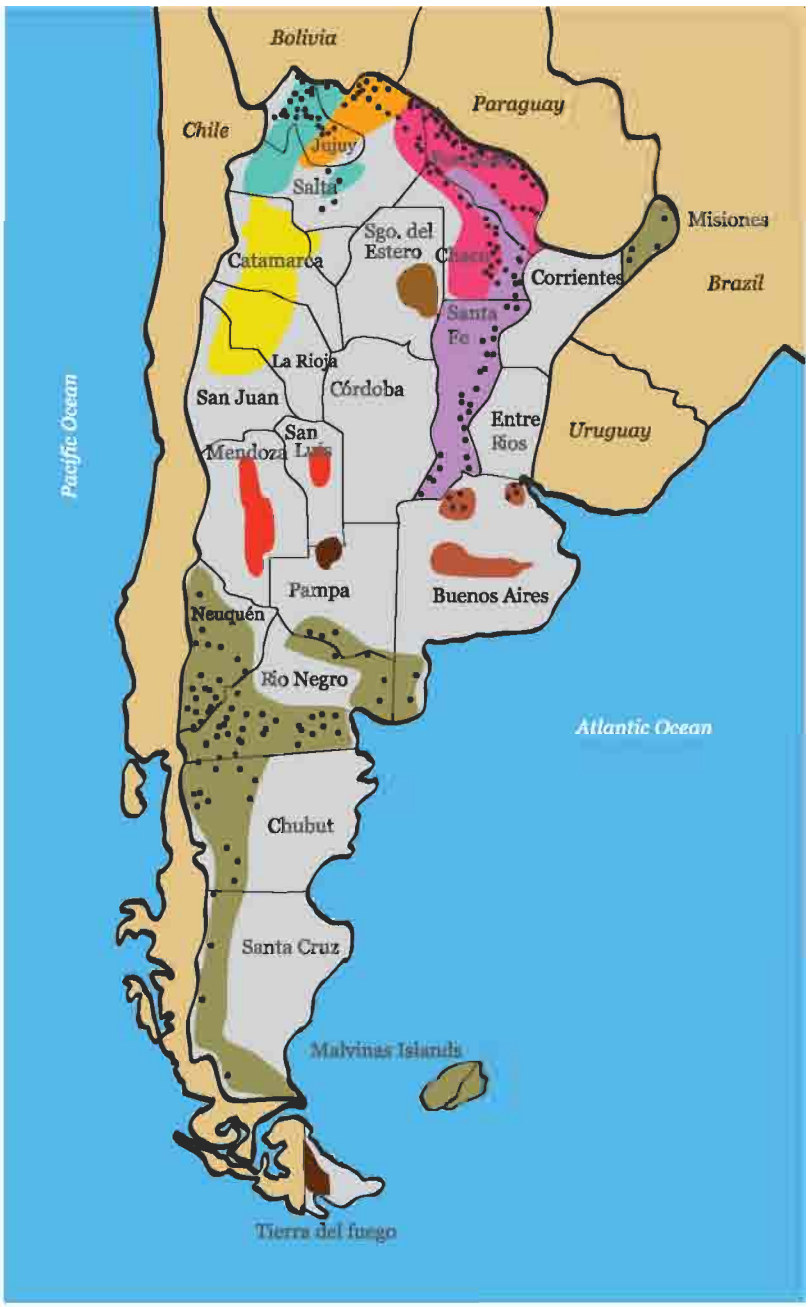
> **Malnutrition:** Undoubtedly, infant undernourishment is the main cause of morbid-mortality in indigenous children. In sanitary zones of the Northwest and the Northeast of Argentina, 80% of the cases of infant malnutritionare determined by parasitism related with the precarious conditions of environmental sanitation.

> **Infectious diseases:** Intestinal and respiratory diseases, skin and mucosa diseases of bacterial, parasitic and micotic origin. In 1993 and 1994 new cholera epidemic outbreaks affected indigenous communities.

> **Diabetes, obesity and alcoholism:** There are no studies to enable comparisons or estimate the situation.

> **Suicide:** There are no studies to enable comparisons or estimate the situation.

Indigenous peoples of **Argentina**



ETHNIC GROUPS

- Kollas
- Chiriguano - Tapiete - Chane
- Wichi - Chorote - Chulupi
- Toba - Pilaga - Mocovi
- Guarani (Mbya - Chiripa)
- Huarpe - Vilela
- Ranquel
- Pampa
- Mapuche - Tehuelche
- Ona and Yanama Creoles
- Diaguita - Calchaqui
- Settlement, Endepa

Belize

1. International agreements and National Policies

International Agreements	Legal Framework		Technical units responsible for Health of Indigenous Peoples	
	Constitution/ National Policies	Health Policies	Governmental instances/Ministry	Contact Information
Agreement 169 ILO CD37.R5 PAHO CD40. R6 PAHO		Health Ministries maintain an atmosphere that is conducive to good health and well-being in a framework that assures fairness, equity and accessibility. The communitarian programs must work proactively to promote prevention. Medical services must operate within the national rules and established protocols to improve services rendered to users.	Health Ministry It should be noted that as per sanitary reform The Health Ministry will no longer be the sole supplier of health services in the country. There are other primary care suppliers in the private sector from which the government acquires health services. Nevertheless, the Health Ministry continues to be a normative organism; namely it dictates norms and protocols and it supervises the health of the population. These initiatives are for all citizens and although they are not specifically directed to natives it tackles high-priority aspects that are significant for indigenous population.	> Mrs. Sandra Hall General manager Health Ministry > William Tam Building Area of Water Reserve Belmopan Belize email: minofhealth@moh.gov.bz

Source: Web Page of the Government of Belize; Health Ministry and Public Service

2. Strategic alliances and networks of inter-institutional and inter-sectorial collaboration

Agreements	None
National, interinstitucional/interesectorial projects	None
multicountry Projects	None
Interinstitutional/inter-sectorial fora	The District of Toledo (Toledo is one of the two districts where most of the indigenous peoples in Belize live) was the principal of intersectorial and interinstitutional collaboration for Health care up to the middle of 1990. Although Toledo's district health team is no longer a functional body, there is a strong inter-institutional collaboration and networks for Health care at a local level.
Indigenous organizations that include health integrated actions in their political agendas.	None. Nevertheless, UNICEF has recently facilitated the organization of pertinent groups indigenous leaders to jointly observe and to advocate for the execution of the Plan of National Action for Childhood, 2004-2015. This plan of action has direct implications for health care and while the action groups will watch and advocate for progress in the District of Toledo, special attention will be given to the equitable treatment of indigenous peoples in the implementation of the plan.
Networks	UNICEF is facilitating the establishment of a Program for the Children and Adolescents of Toledo in order to facilitate the government's commitments through a national plan for children and adolescents.

3. Primary health care and interculturality

Policies that promote the incorporation of indigenous perspectives, medicines and therapies in National Health Programs.	Within the priority framework for primary health care, emphasis has been placed on the significant participation of natives in the provision of services. (e. g. It is established that nurses from the community are the first point of formal contact for indigenous communities with the Health Ministry).
Harmonization of experiences of indigenous and conventional health systems.	Traditional midwives and auxiliary nurses of the community where the instructors, promote the incorporation and continuation of good traditional practices in pre and post childbirth care.
Associations of indigenous therapists	None
Programs for training and development of human resources (research and scholarships)	None

4. Information, analysis, monitoring and management

Information on the demographic, socioeconomic and epidemiologic profile of Indigenous Peoples	Data is not divided by ethnic group. Nevertheless, the highest incidence of poverty is in the Southern part of the country where most of the natives. Other social indicators for this region are less relevant for the rest of the country.
Information systems, monitoring and evaluation of health of Indigenous Peoples include variable ethnicity.	None
Maps of location of Indigenous Peoples in the countries according to political division of the country (including map in annex)	see Attachment *(pag. 30)*
Characterization of Indigenous Peoples with respect to their life and health condition, social organization and systems of beliefs and values that influence in the maintenance and restoration of their health.	Information not available
Periodic publications regarding health of Indigenous Peoples	None
Section on health of Indigenous Peoples in the Web page of Health Ministries, PAHO or other institutions (electronic mail)	None

Second part

1. What are the most relevant achievements in the health care of Indigenous Peoples in the period 1995-2004?

> Perhaps the most significant achievement that has had an impact in the health of Indigenous Peoples is the political commitment of the current government to investing in raising the life standard of those living in the South of Belize so that it is comparable to the rest of the country. With this aim, the Government has made a significant investment in water systems, sanitation and control programs of vectors, construction of schools and houses for professors in the most remote communities. In the last ten years, the secondary road construction has significantly reduced the geographic isolation of the indigenous communities.

> This commitment is the result of poverty studies of 1992 that revealed that poverty is prevalent among Indigenous Peoples in the country.

> Health of indigenous peoples in Belize has also been benefited from the improvement of electricity and rural program of water and sanitation. According to the last report of human development of the country (1997), 69% of the rural communities have access to a source of drinking water. From this coverage, 53% have access to a rudimentary water supply source and 16% of access to manual pumps. This report states that the total coverage for sanitary establishments is 22%. Although there is no statistic that can be proven, regarding the relation of these investments and health of Indigenous Peoples; it must be stated that the establishments of public health in the south region have seen a reduction in the incidence of diseases transmitted by water and a diminish in maternal and infant mortality rates over the last ten years.

> Adjustments made to the National Maternal Infant Program to improve the coverage of rates of immunization, pre and postnatal care in rural communities have also had a positive impact in the health of Indigenous Peoples of Belize. The collaboration with NGO and the organisms of United Nations to train communitarian and voluntary agents have contributed to improve the capacity of the Indigenous Peoples to provide direct health care (handling and treatment of diarrhea and malaria, sanitary education and monitoring and notification on environmental conditions that affects health) to its communities. Indigenous Peoples formally recognize them as part of health system in their function as aids of communitarian infirmary (community workers of rural health), voluntary collaborators for malaria and the control program of vectors and traditional midwives.

2. What are the high-priority problems in the Health care of Indigenous Peoples of the country in the national and sub national scope?

> Belize recognizes two ethnic groups as native; garífuna and the Mayan (Kekchi and Mopan). Current tendencies indicate that they are constantly migrating from their traditional communities and getting involved in the economic activities of Belize. Today, Belize has the highest HIV rate of infection in Central America and the fifth highest in the Caribbean due to changes in the way of life of natives who try to integrate themselves in the established society. Today, HIV infection is the greatest health risk. Health risks associated with lack of food security would be in second place and occupational health, in third place, especially due to work in aquaculture, banana and citric production areas due to life and environmental conditions.

> A National Census of Stature by Age made in 1996 reveals that 15.4% of the students within six to nine years of age suffer from growth delay. The highest level of growth delay took place in the District of Toledo (39.0%), compared with the other Districts that included/ between 4% to 18%[1]. From the data of the survey, the 2001 Health Report Evaluation of Belize reveals patterns that individualize the Mopan and Kekchi peoples as having the highest rates of transmissible diseases among native ethnic groups of the country. These diseases arise from the precarious environmental conditions (for example, malaria, anemia and other nutritional deficiencies mainly of vitamin A and Zinc); the lack of institutional support (for example, lack of nurses and doctors), the lack of infrastructure (water and disposal of waste)[2]. Although government, because of its political commitment has significantly progressed when approaching these subjects, great part of infrastructure problems and atmosphere are still pending.

> Locally, food and nutritional security, family health (reproductive health) and the sanitation are three of the most significant subjects of health. It is also important to indicate that the priority for the government is the sanitary reform and the scheme of national health insurance; the repercussion of this new method for rendering services to natives of Belize has still not been totally evaluated. Due to current tendency of changes in life styles, there is a notorious increase in the incidence of chronic diseases as the diabetes, hypertension, cancer and AIDS between both Indigenous Peoples in Belize.

> Although there are significant achievements related with installation of rural water systems, it is still pending the subject of quality control and the necessity of continuous education in environmental sanitation. It is evident that changes related with education of Indigenous Peoples are expected as well as practices to improve their own health. The economic crisis that today affects Belize threatens the capacity of the government to maintain their program of primary health care and support infrastructure, therefore, the safety network for Health care of Indigenous Peoples is also threatened.

> In addition, these health problems are not of high-priority in the agendas of Indigenous Peoples. The advocacy to make sure that the strategy of current health care is not eroded by the national sanitary reform does no exist. For example, the current emphasis area for Mayan leadership is the acquisition of community land.

> The degradation of the environment is one of the problems that pose a serious threat for the health of indigenous peoples of Belize. Current economic situation of the country demands that peoples should depend more from cash income. This puts pressure on natural resources in areas were natives live as they demand and exploit these resources to use as a basis of their cash income to provide education and health to their families. The increase in the demand of land for traditional agriculture and the establishment of new dwelling are the main factors that contribute to the degradation of environment, which finally threatens food security as the degradation of soil reduces the production of food.

> Most recent statistics indicate that the south of Belize is the zone of the country with the highest incidence of poverty. This is also the area natives of the country call their home. Therefore, mitigation of poverty must have a fundamental consideration in the renewal of the strategy for primary health care and the attainment of the Development Millennium goals. Other considerations include disparity of gender, geographic isolation, low level of literacy, culture and traditions related with perceptions of Indigenous Peoples of their own health and community governments.

[1] Food Safety and Nutrition at local level; The Toledo Experience, Belize 2000-2004; PAHO/INCAP

[2] Belize Health Report, 2001

Strategic analysis	
Strengths: particular characteristics of the country that would facilitate the actions regarding improvement of health of Indigenous Peoples.	**Weaknesses:** negative aspects inside the country that would make difficult actions tending to health improvement of Indigenous Peoples.
> The commitment of government with mitigation of poverty. > The collaboration with the non governmental organizations, cultural advisors and governmental organizations. > Policy open to participation of Indigenous Peoples to compete for ministerial positions in rural development. > The participation of natives as providers of primary care in their communities. > The flexibility in the programming of national health to comply with the specific needs of Indigenous Peoples. > The traditional government system of Indigenous Peoples.	> Health care is not a priority in the agenda of Indigenous Cultural Councils, main defenders of well-being of Indigenous Peoples in the country. > The lack of disaggregated data by ethnic belonging, in fact the data that are collected are to determine national situation. In addition, the data collection instruments do not evaluate the peculiarities of the situation of Indigenous Peoples. > The lack of national social policies sensitive to traditions and cultures of Indigenous Peoples and that approach their special necessities regarding basic services. > Deficient organization of Indigenous Peoples; as a result they cannot approach social themes that affect them (different groups are not united to approach the common problems).
Opportunities: factors that are in the context, and are believed to act in favor of actions tending to improve health of Indigenous Peoples.	**Threats:** negative factors that can affect the implementation of actions tending to the improvement of health of Indigenous Peoples.

Strategic analysis	
> Existence of traditional knowledge for cure, herbal remedies and food security. > Collaboration and creation of networks to improve integrated actions regarding health themes of natives through the Coordinating Committee of Toledo for the Plan of National Action for the Adolescents and Children. > Rural program of health care; auxiliaries of community nursing. > Sanitary Reform	> High at level of political interference in the execution of programs at community level, where Indigenous Peoples are very affected. > Poverty and economic instability; current economic situation threatens the capacity of the government to maintain its level of investment in primary health care. > High level of paternalism and dependency among Indigenous Peoples. > Current tendencies of soil degradation and lack of security in land-tenure system > Economic crisis

Third part

Table1. Population and Indigenous Peoples of Belize

Indigenous peoples	% Total Population (Stann Creek)	% Total Population (Toledo)	% Indigenous Population (Stann Creek)	% Indigenous population (Toledo)
Garifuna	45.4	12.5	88.7	18.1
Mopan Maya	5.5	25.2	10.83	36.54
Kekchi Maya	0.2	31.2	0.45	45.26
Other	48.8	31.2		

Source: Central office of Statistics. 2001. Summary of Statistics. Printed by Government of Belize.

Table 2. Challenges, factors to consider, and inequities (part 1)

> Challenges

Health strategies and public health must include and approach risk structural factors and become inserted in the strengths of Indigenous Peoples.

Maintenance of the safety network for Health care of Indigenous Peoples.

Factors to consider

> **Location:** Indigenous Peoples of Belize (Maya Kekchi and Mopan) and the Garífuna are predominantly located in the south of Belize. Two of the main cities (Punta Gorda and Dangriga) in this region are known as garífunas communities. There are other four Garífunas cities, Hopkins, Siene Bight and Georgetown in the Stann Creek and Barranco District in the District of Toledo. The Garífunas lives in urban, coastal zones of the south. The Mayan mainly live in the rural zone of Toledo, where because land arrangement, they are affected by geographic isolation to social services and participation in work that requires qualification.

Ethnic and cultural heterogeneity in Belize:

> **Culturally appropriate care:** The Maternal Child Health P rogram (SMI) reflects the efforts of the government of Belize to improve the access to basic health care for Indigenous Peoples. The SMI program has mobile clinics to remote zones using as their main support the communitarian nursing aids. The program also has incorporated traditional midwives as part of the formal rendering of services. The program has collaborated with non-governmental counterparties to train traditional midwives to improve their skill and allow them to complement their traditional practices with those of attention of conventional health. The natives are community nursery aids and traditional midwives.

> **Inequity:** the integrated action of health in Belize is national; there is no program exclusively focused in Indigenous Peoples. It is enough to say that the quality and level of care available in the areas where the natives live are inferior in comparison with the level of care available in other areas of the country where indigenous population lives. This largely is due to determining factors used by the government to allocate resources for health care namely proportion of population and prevalence of certain diseases. Toledo has a primary care hospital, this means that the procedures like Cesarean Operations are transferred outside the District. Health care provided by government to a great extent is subsidized as it is offered by voluntary medical teams.

> **Poverty:** 79%, corresponding to 67.5% of all the population lives below poverty line. The Mayans were considered the poorest ethnic group and significantly contributes to the young population of Toledo (rate of fecundity is 5.6 children per woman). Between the Mayans, the women and the children are extremely vulnerable and tend to present deteriorated health conditions (undernourishment) as a result of poverty. It is important to mention that the gap of poverty for Toledo (44.4%) is significantly higher than the national average of 11.1%. The incidence of poverty in 2002 was higher among Garífunas and Maya than in 1995. The incidence of poverty increased to a 6.6% among the garífunas; of 10% in 1995 to 16.6% in 2002 and among Mayan peoples a 7.7%; of 65.8% in 1995 to 73.5% in 2002, while there was a decrease in the incidence of poverty among Creole and mestizo peoples, two majority ethnic groups of the country.

> **Illiteracy :** 38% of natives is considered illiterate in comparison with the national average of 26,1%.

Table 2. Challenges, factors to consider, and inequities (part 2)

> **Unemployment:** 10% of the second lowest average of the country. Nevertheless, due to the nature of work market in these areas, there is a significant number of under employment. Although data are not known, a significant number of 10% of employees work on their own in small scale or subsistence agriculture. It should also be noted that while the remainder of the country has job opportunity as a result of its industry, the south of Belize, specially the District of Toledo does not have any industry.

> **Utilities:** There is a ministry of rural development that looks after installation of BASIC community infrastructure. Currently a program that seeks to improve communication and transportation by improving roads and bridges is underway. The Health Ministry and other volunteer medical teams conduct mobile health clinics to communities where indigenous groups live. Services include maternal and child health and monitoring and treating of lifestyle related diseases (chronic diseases). There is a Ministry of Rural Development that controls the installation of basic infrastructure of the community. Now there is a program that tries to improve communication and transport on basis of improvement of the roads and bridges. The Health Ministry and other medical team of volunteers lead the mobile clinics to the communities where natives live. The services include maternal child health and monitoring and treatment of diseases related to life style (chronic diseases).

> **Infant mortality:** in the Stann Creek District , it is 28,3 per 1000 born alive and in the Toledo District 21,5 per 1000 born alive (although this is not a specific information for natives, it reflects the situation of all the population of the region). Both averages are significantly higher than the national average of 17.1 per 1,000 born alive.

> **Immunization:** information available for immunization does not specifically reflect the coverage by ethnic groups in the country, the coverage rates of vaccination for Toledo are 99.3% for BCG, 97.5% of oral polio vaccine, DPT/HepB/Hib (Pentavalent) 95.1%, MMR 88.3% and coverage rate of vaccination for District Stann Creek are BCG 96.8%, oral polio vaccine 93.8%, DPT/HepB/Hib (Pentavalent) 94.8% and MMR 88.3%.

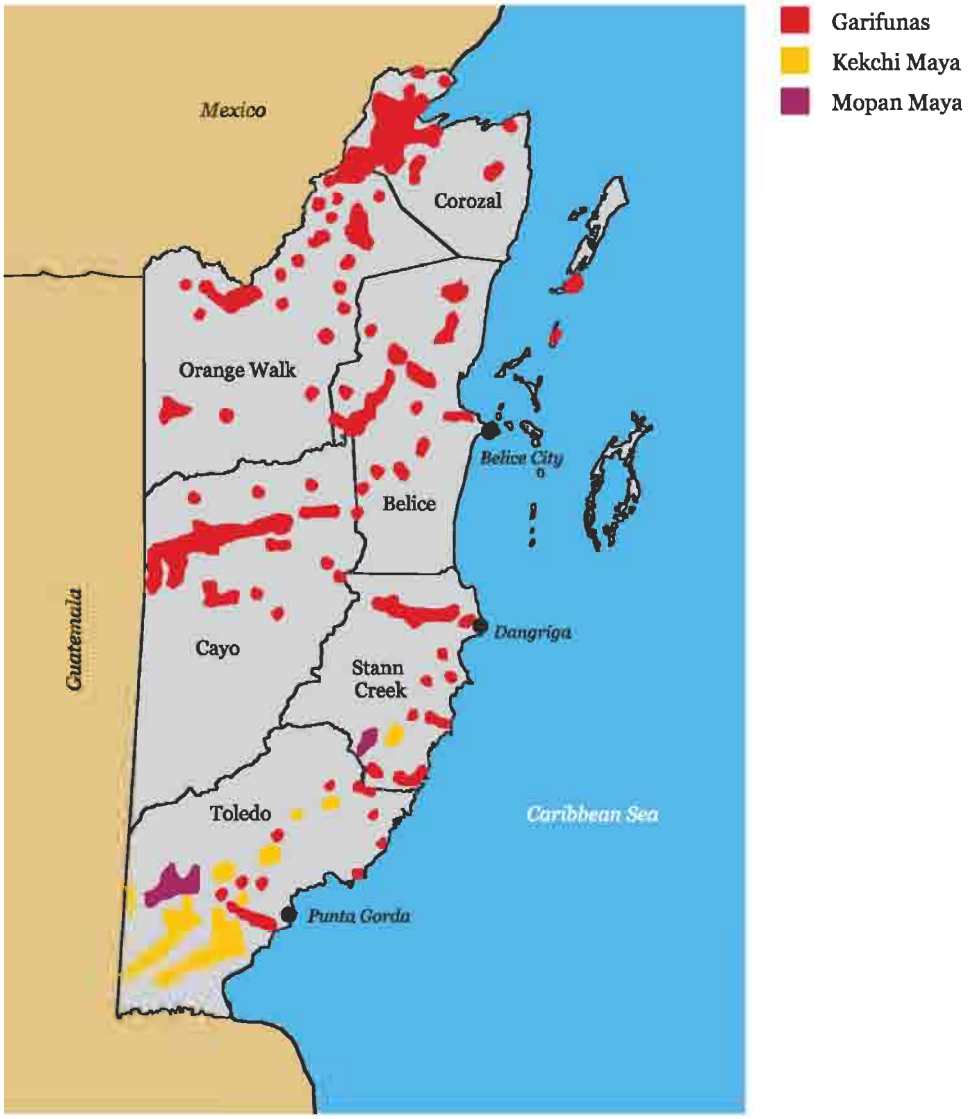
> **Maternal mortality:** in the Stann Creek District, 116 per 100.000 and in Toledo 134,4 per 100.000, both data are significantly higher than the national averages of 40,5 per 100,000

> **Undernourishment:** National Census of 1996 on Stature according to the age shows that the greater rate of retardation in growth is in the District of Toledo (39%) compared with that of other Districts that have a rank between 4% and 18%

* Information on infectious diseases is not available

Sources: Basic indicators of Belize; Unit of Epidemiology, Health Ministry and Communication; July 2004.
Forum on Poverty and Development in Toledo, Ministry of Economy and Development, November 2003.

Indigenous peoples in **Belize**



Indigenous Communities in **South Belize**

Indigenous Communities District Stann Creek

>Garifuna Communities:
>Dangriga Town
>Siene Bight
>Hopkins
>Georgetown

>Maya Communities (Mopan)
>Maya Mopan
>Red Bank
>Maya Centre

>Maya Kekchi Communities
>San Roman
>Santa Rosa
>San Pablo

Indigenous Communities District of Toledo

>Garifuna Communities
>Punta Gorda Town
>Barranco

>Maya Communities (Mopan)
> Pueblo Viejo
>San Antonio
>Crique Jute
>San José
Santa Cruz
Santa Elena
Na-Lum-caj

>Maya Communities (Kekchi)
>Boom Creek
>San Felipe
>Santa Ana
>Midway
>Conejo Creek
>Sunday Word
>Crique Sarco
>Laguna
Mabilha
Jordan
Otoxha
Dolores
San Benito Poite
Jalacte
San Vicente
San Pedro Colombia

>Blue Creek
>Aguacate
>Santa Teresa
>San Lucas
>Indian Creek
>Medina Bank
>Corazón Creek
San Miguel
Silver Creek
Big Falls
San Marcos
Golden Stream
Bladden

Bolivia

1. International agreements and national policies

International agreements	Legal frameworks		Technical units responsible for The Health of Indigenous Peoples	
	Constitution National Policies	Health policies	Governmental instances /Ministry	Information of contact
1991. Agreement 169 ILO, was ratified by Law 1257 dated on July 11th, 1991, suggest the obligation of the State to apply public policies with the effective participation of Indigenous Peoples and the recognition of collective rights in their favor. **1993.** Resolution CD37.R5. **1997.** Resolution CD40. R6.	National Constitution **1994.** Reform of the Political Constitution. **Art. 1:** The Republic of Bolivia is "a multiethnic and pluricultural" nation. **Art. 171:** The social, economic and cultural rights of Indigenous Peoples that live in the national territory are recognized and respected, regarding their communitarian lands of origin, identity, values, languages, customs and institutions. **1994 Law of Popular Participation.** Enact on April 20th, 1994, redefines to the Municipality under a territorial vision. **Art. 1:** It promotes process of popular participation of the indigenous communities and farmers. **Art. 14:** It adds new tasks to the municipalities, as education, health and sports. **1995.** Law Nº 1654 of July 25th, 1995 or Law of Administrative Decentralization, along with the Law of popular Participation are advances towards a more participative democracy. **2000.** Law of Dialog. Process of deliberation established between the civil society and the State, constitutes the National mechanism of Social Control of Bolivia (MNCS), the D.S.	**1987.** Regulation for the practice of Traditional Naturist Medicine, approved by Ministerial Resolution Nº 0231 on March 13th, 1987. **1998.** Basic Health Insurance, created by DS 25265 on December 31st 1998. **2001. *Regulation of Basic Health Insurance.*** Approved by Ministerial Resolution Nº 0182 May 10th, 2001. **Art.6.** The SBS covers attention of pregnancy and its complications, as well as prevalent diseases that affect children under 5 years old and population in general. **2001.** Norms for natural, traditional and homeopathic medicines, defined by Ministerial resolution Nº 0013 on January 16th, 2002. **2002.** National Health Policy strategies: primary care, shared management, social inclusion, elimination of discrimination in the attention of the indigenous population. On January 18th 2002, it is decided the declaration of D.S. Nº 26330 that creates the Insurance of Indigenous and indigenous Health.	> Ministry of Indigenous Affairs and Peoples. > Vice ministry of Rights and Policies of Indigenous Peoples. > Health Ministry and Sports. > Vice Health Ministry, Main Direction of Health Logistics. > Direction of Development of Health Services. > Main direction of Prevention and Control of Diseases.	> Mr. Ricardo Calla Ortega, Minister of Indigenous Affairs ricardocalla@hotmail.com > Ms. Maria Eugenia Choque Vice-minister of Rights and Policies of Originary Indigenous Peoples maeucho@entelnet.bo maipoviceministerio@yahoo.es Tel. (591) 242-4466. > Dr Rosario Quiroga www.sns.gov.bo Tel. (591) 244-0915 > Dr Eduardo Chávez, Tel. (591) 244-0915 > Mr. Ronald Lagrava rlagrava@reforma.org.bo

	26564 on April 2nd, 2002, regulates the attributions of this mechanism. **2000.** Bolivian strategy for Reduction of Poverty (EBRP). Originating resources of the condemnation from the external debt are used, within the framework of initiative HIPC (Highly Indebted poor countries) proposed by international organism and creditor countries.	**2002.** Law 2426 on November 21st 2002, creates the Universal Maternal and Child Insurance (SUMI) article 8, about uses and customs. **2002.** SUMI Regulation, establishes the creation of the Local Directories of Health (DILOS), higher authority in "management shared with popular participation in health" for the fulfillment of the National Health Policy, the implementation of the SUMI and the application of prioritized programs by the municipality (Art. 7. II).	

[3]Bolivia carried out two subnational worshops in Santa Cruz and La Paz to complete the evaluation instrument.
The complete document of these evaluations is included in the records of the Health Program of Indigenous Peoples of the Americas in the Headquarter of PAHO.

2. Strategic Alliances And Networks Of Interinstitutional And Intersectorial Collaboration

Agreements	To be defined
Intersectorial interinstitutional projects.	> The National Mechanism of Social Control of Bolivia constituted from the Law of National Dialogue (2001) has invited the organization of International Action for Health (AIS) and the Committee for the Defense of Consumer rights (CODEDCO) to coordinate efforts with differe health institutions in order to verify the impact in the health sector of EBRP and HIPC initiative. > The International Association of Promotion, World Bank and Health Ministry and Sports (MSD) intervened in the projects: SUMI, Extended Program of Immunizations, Program Nutrition, AIEPI and EXTENSA Programs (for the reduction of maternal and child mortality rates). > The UNFPA and Health Ministry participated in the Sexual and Reproductive Health program > The delegation of the European Commission and the MSD faced the Hygiene and Basic Health Program PROHISABA in Tarija and Potosí > The Inter-American Development Bank along with Health Ministry took part in the National Program of Chagas, the Extended Program of Immunizations, the National Program of Blood donation points and SINAVIS-INLASA. > PAHO/WHO helped to the Ministry of Health and Sports Ministry (MSD) in the development of health policies, environmental health, essential medicines, analysis of the health situation and its tendencies, technical cooperation and scientific information. > The World-Food program (PMA) in coordination with the Ministry of Health and Sports executed the National Program of Nutrition. > UNICEF and MSD participated in: the National Program of Nutrition and HIV/AIDS Program. > Belgium and French Cooperation (IRD) supported MSD in INLASA project destined to the research on the congenital transmission of Chagas the researches on the consequences of malaria during pregnancy and characterization and control of vectors. > Socio sanitary Project in Potosí (PAHO/Italian Cooperation/MSD/Municipality of Potosí) 2000-2002. > Project Development in Departmental Health POTOSI COPI/PAHO/MSD/Municipality 2004. > CAUSANANCHISPAJ/PAHO/MSP Maternal Strategy of Intercultural Health. Regional program for Support to the Indigenous Peoples of Amazon River basin; International Fund of Agricultural Development FICA; Corporación Andina de Fomento CAF (1996). > PAHO/WHO supported the Assembly of the Guaraní and COPICHAS Peoples for implementation of projects and activities of institutional strengthening and integrated actions of high-priority problems.
Multicountry Projects	> Institutional development of the Coordinator of Organizations and Indigenous Peoples of South American Chaco (COPICHAS), Bolivia, Argentina and Paraguay. > Trinational project of Bolivian Chaco.
Indigenous organizations that include the integrated actions of health in their political agendas.	> Confederation of Natives of Bolivia (CIDOB). > Union confederation of Farm Workers of Bolivia (CSUTCB). > Council of Suyus, Aymaras and Quechuas (CONSAQ). > Confederation of Ayllus and Markas of Collasuyo (CONAMAC). > Confederation of Indigenous Peoples of South American Chaco (COPICHAS). > Meeting of Guaraníes Peoples (APG).

3. Primary Health Care And Interculturality

Policies that promote the incorporation of indigenous perspectives, medicines, therapies in National Health Programs.	> **1995-2002.** Basic Health Insurance. > **2002.** National Health Policy, strategies: primary care, shared management, social inclusion. elimination of discrimination in the attention of native population. > **2002-2004.** Universal Maternal and Child Insurance. > Extension in Health (EXTENSA) Mobile Health Brigades Technical unit of Indigenous Health in Health Ministry. > **2003.** National Medicine policy.
Harmonization experiences of indigenous and conventional health systems.	Experiences isolated from state health system , in charge of Indigenous Peoples, as it is the case of the Captainship of the El Alto y Bajo Izoso in the Guaraní community. Integration of the Kallawaya medicine, in the Bolivian Spanish Health Center Kallawaya Hospital, Curva Shoquena Huasi, La Paz; Hospital San Ignacio de Velasco, Chiquitanía.
Associations of indigenous therapists.	Bolivian Society of Traditional Medicine (SOBOMETRA), Bolivian Institute of Traditional Medicine (INSBOMETRA), Confederation of Naturist and Traditional Doctors (IT COMMENTS), Confederation of Naturist Doctors, Natives of Kollasuyo (CONMIK), Bolivian Foundation of Natural Medicine (FUNDOMENT), Institute of Traditional Kallawaya Medicine.
Programs for training and development of human resources (research, scholarships).	Postgraduate Course in Intercultural health (WILAQKUNA) University Tomas Frías POTOSI, Course on Traditional Medicine University Francisco de Asís.

4. Information, Analysis, Monitoring And Management

Information on the demographic, socioeconomic and epidemiology profile of Indigenous Peoples.	"The socio demographic characteristics of the indigenous population" appear in the publication of the National Institute of Statistics (INE) with data of 2001 Census, information in www.ine.gov.bo
Information, monitoring and evaluation systems of health of Indigenous Peoples include variable ethnicity.	In the National Health System (SNIS), there is no possibility of obtaining the identification of the population by its ethnic condition, thus, it is impossible to this date to establish their situation, coverage and other data. In 1997, PAHO, within the framework of Health Initiative of Indigenous Peoples of the Americas promoted the preparation of an analysis document "Health Situation of Indigenous Peoples of Bolivia", and also to perform a research of scientific and technical resources on health of Indigenous Peoples to be able to access to this information via electronic connections.
Maps of location of Indigenous Peoples in the countries according to the political division of the country (include map in the annex).	Map of distribution of Indigenous Peoples, Ministry of Indigenous affairs and Peoples, 2001. *(page. 53)*
Characterization of Indigenous Peoples regarding their life and health conditions, social organization and their subjects of beliefs and values that influence in the maintenance and restoration of their health.	There are only studies regarding some indigenous regions or specific peoples. The existence of 37 Indigenous Peoples diverse in traditions and culture makes it difficult to extend these results to the whole. MORENO, Rita Paola (1996) Report on documents compiled on health of Indigenous Peoples, PAHO/OMS, La Paz (unpublished document).
Periodic publications on health of Indigenous Peoples.	They do not exist.
Section on health of Indigenous Peoples in the Web page of Health Ministry, PAHO and other institutions (electronic mail).	**CIDOB** www.cidob.org.bo **(Indigenous Confederation of Bolivia).**

Second part

1. What are the more relevant achievements in the health care of Indigenous Peoples in the period 1995-2004?

In general there were no achievements for Indigenous Peoples from rural highlands. The partial achievements were:

- Law 1737 of Natural and Traditional Medicines.
- Creation of National Sub commission of Natural and traditional Medicine.
- Construction of hospitals that integrate traditional medicine in the locations of Curva, Charazani, Amarete, Patacamaya, Chapare and Huancollo.
- The law SUMI that provides integration with the traditional medicine.
- Recognition of Traditional Medicine represented by Kallawuaya medicine by UNESCO as an oral and intangible heritage of mankind.
- Participation of traditional doctors in the campaign against the tuberculosis.
- Communal pharmacies with natural traditional and western medicines.
- Laws that recognize Indigenous Peoples.
- International cooperation that directly supports Indigenous Peoples.
- Recognition of the national authorities to the School of Health of Bolivian Chaco.
- Administrative resolutions of SEDES, Santa Cruz for the operation of doctor's offices of traditional doctors.
- Epidemiologist study of the Chaco with participation of health ministries and PAHO of the three countries.
- Departmental decentralization of SEDES.
- Integration of Traditional and Western Medicine in the province of San Ignacio
- Development of the legislative aspect, enactment of Law 1257 (homologation of Agreement 169 of ILO), of the traditional medicine law and SUMI Law.
- Trinational calls (Health Ministry of Argentina, Bolivia and Paraguay) to develop projects in health and to manage health problems of the South American Chaco.
- Decree 0231 that recognizes Traditional Medicine associations.
- Development of integration experiences of Traditional Medicine with Western one in Santa Isabel Hospital in the province of San Ignacio de Velasco and in Santa Cruz Department.
- Decentralization of the international cooperation in health namely PAHO in the department of Santa Cruz.
- Starting of integration process between Western Medicine and Traditional Medicine.

2. What are the high-priority problems in the health care of Indigenous Peoples in the period 1995-2004?

- The objectives and goals in indigenous health proposed by congress and seminaries in rural areas were not achieved.
- The economic resources are not directly beneficiary for rural areas
- SUMI does not reach Indigenous Peoples, because it is limited to urban area.
- Lack of coordinated work in health establishments between Traditional and Western Medicine.
- Lack of support in infrastructure, lack of drinking water, routes of communication, electrification and education on health and hygiene.
- Lack of health personnel, basic equipment, medicines and ambulances in indigenous populations. There is no suitable planning for provision of medicines.
- Limited popular participation in municipalities.
- No indigenous participation in DILOS (Local Health Directors) and they do not work adequately.

- High rate of infant mortality by EDA.
- The economic resources of HIPC II do not reach municipalities (Programs for relief of external debt of poor countries that are highly indebted).
- Insufficient attention for children with malformations.
- Lack of information regarding rights in health.
- Difficult access to rural indigenous communities.
- Discrimination against natives and peoples without economic resources.
- Breach of law 1257 that ratifies agreement 169 of ILO
- Lack of cultural adjustment of primary health care.
- Trained indigenous personnel are not incorporated as personnel appointed and financed by General Treasure of the Nation (TGN).
- The Indigenous Health Council is not recognized in the presentation and development of national Health policies.
- There are geographic and economic barriers to reach health services.
- Lack of confidence and credibility of health services for maternal care.

3. What needs to be considered in the insertion of the health of Indigenous Peoples as a priority in the processes that the country is promoting in the renovation of Strategy of Primary Health Care and in the fulfillment of the Millennium Goals Development?

- Insertion, integration and institutionalization of traditional and naturist medicine in Health Ministry, SUMI, hospitals, first aid posts and traditional communal pharmacies.
- Revaluation and registry of natural and traditional products.
- Work coordinated between academics and traditional doctors.
- Interculturality should be included in programs of secondary and higher education.
- Creation of indigenous universities for greater training of community.
- Indigenous representation in the Departmental Health services (HOST) at a national level.
- Greater support in mass media for dissemination of health themes.
- Deepening of health agreements for Indigenous Peoples and a better application of SUMI law.
- Qualification and information of natives in political instances of health.
- To include the vision of Traditional Medicine regarding prevention and self-management in the strategies of primary health care.
- Appoint a Director of Traditional Medicine in Health Ministry
- Incorporate medicinal plants in health services.
- Improve the operation of DILOS.
- Incorporate traditional doctors including midwifes in the public health services.
- Recognition by the Health Ministry of the attention of traditional doctors in SUMI and they need for remuneration.
- Hold programs to train of traditional doctors.
- Formulate and develop of policies for those disabled in indigenous population and assure their reintegration into society .

Strategic analysis

Strengths: particular characteristics of the country that would facilitate actions for health improvement of Indigenous Peoples.	**Weaknesses:** negative aspects inside the country that make the actions difficult to improve the health of Indigenous Peoples
> Integral and preventive treatment of traditional medicine. > Traditional doctors are recognized by society and have permanence in the communities (live pharmacy). > Traditional specialists (Kolliris, Yatiris, Amautas, Jampiris, Kallawayas, etc.) and the preservation of traditional knowledge. > Great wealth of biodiversity for the traditional medicine in Bolivia. > Organizations and institutions with traditional medical knowledge that work by this. > Interinstitutional agreements. > There is the will and decision of civil and institutional society regarding traditional medicine. > National recognition of indigenous organizations. > Interinstitutional agreements. > Human and natural resources available for Indigenous Peoples. > Will and decision of civil and institutional society in favor of traditional medicine > Indigenous Peoples have maintained their culture, practices and knowledge. > Indigenous presence in parliament. > Existence of legal frameworks that recognize the rights of Indigenous Peoples.	> Lack of training of traditional doctors in the preparation of projects for obtaining financing. > Acculturation and devaluation of knowledge. > Environment Ministry has not been integrated into the protection of medicinal plants. > Lack of national regulation and technical means for the protection of knowledge and traditional plants. > Lack of effective coordination between traditional doctors and Health Ministry. > Proliferation of organizations and institutions that work with traditional medicines. > There are no national policies regarding extinction and pillaging of fauna and flora. > Insufficient basic services > Poor use by the State of natural resources. > Weak presence of health policies. > Traditional medicine is not articulated and has a dispersed presence. > Weak organizational and leadership capacity. > Persistence of discrimination against indigenous populations. > Weak participation of indigenous organizations in institutions of national and departmental governments. > Lack of quality, warmth and cultural adjustment in health services. > Limitations of education system regarding training in health > Nonexistence of norms that protect the intellectual property on medicinal plants
Opportunities: factors that are in the context and that are deemed to act in favor of actions tending to improvement of health of Indigenous Peoples	**Threats:** negative factors that affect the implementation of actions to improve the health of Indigenous Peoples.
> Recognition by UNESCO of the Kallawayas. > SUMI Law. > Research on medicinal plants.	> Foreign product invasion. > Minimal transmission of medical knowledge by indigenous healers > Proliferation of religious sects.

Strategic analysis	
> Demand of medicinal plants in diseases such as AIDS. > Possibility of external financing for support to traditional medicine. > There is interest from international bodies to support traditional medicine. > There is a sub commission of natural products at national level. > Process of citizen participation with national and international cooperation. > International and national Agreements. > Favorable opinions with respect to traditional medicine. > Environment not contaminated and great biodiversity. > Process of the Constituent Assembly for indigenous autonomies. > International cooperation that prioritizes investment in the development of Indigenous Peoples.	> Contamination of the environment (forestry burning, fertilizing, transgenic, etc.). > Free Trade Agreement of the Americas. > The smuggling of herbal products. > False traditional doctors and poor use of natural resources. > Weak management of Government. > Weak control of the State regarding the fulfillment of agreements and norms. > Risk of politization or political interference in health programs. > Existence of corruption, national division and interests of peoples and groups. > Globalization and privatization. > The underdevelopment of the country as a result of dependant economic policies. > Division in indigenous movement. > Public social investment is reduced. > Loss of culture and language due to acculturation.

Third part

Table 1. Population and Indigenous Peoples of Bolivia

National Population	Indigenous population according to census ethnic indicator	Number	%	Peoples
8.274.325	> By mother tongue	3.718..969	44,94	37
	> By spoken language	4.133.138	49,95	
	> By self pertaining or auto adscription	5.134.218	62,05	

Source : Census 2001, Bolivia

Note: There are three indicators applicable to the identification of the indigenous population:

I) the language that all the peoples declared to speak (0 and more years);

II) the language that peoples of four years and more declared they have learned to speak;

III) population of fifteen year and older that declared to belong to an indigenous peoples (population of 15 and more = 5.064.992).

[16]It is important to indicate that in the publication of INE "Socio demographic characteristic of indigenous population of Bolivia" (2001), for the construction of data referred to education, employment, fecundity, mortality, etc., considers as native the person who speaks one or more indigenous languages.

Table 2: Challenges, factors to consider and inequities (part 1)

Challenges

> The current situation of the statistical invisibility of the indigenous population as a social group does not accurately establish their present situation or establish the gaps that separate the indigenous population from non indigenous one. It is also a reason why public social investment is not directed at indigenous groups or why greater vulnerability risk and exclusion are not taken into account.

> The application of inter culturality in State policies and its insertion in all the structures of the executive power to obtain an integrated governmental action in that framework should also imply a strategy of affirmative action in favor of the indigenous population due to their situation of vulnerability, exclusion and inequity.

> To extend the contents the indigenous holistic vision towards different levels of social and cultural life of the country, it is necessary to indigenous cultures.

Factors to consider:

> **Location:** Quechua (1.555.641 peoples) and Aymara (1.277.881) Peoples constitute most of the population in the Andean departments West of the country. The Aymara in the Departments of La Paz, Oruro and part of Potosí and the Quechuas in the Departments of Cochabamba, Chuquisaca and part of Potosí. These people constitute the majority in the cities of La Paz, Oruro and Cochabamba.

Indigenous Peoples in the Low Lands, (the Amazon Region, East and Bolivian Chaco are 35); representing 3% of the population of Bolivia.
Several peoples are multinational descent, mainly of Aymara, Quechua or Guaraní.

It is important to consider two aspects: on the one hand, the challenge to define policies for a population that is demographically rural and urban majority. On the other hand, it is hard to define policies and strategies for Indigenous Peoples that are in a situation of high vulnerability or extinction.

> **Ethnic and cultural heterogeneity:** The thirty seven Indigenous Peoples of Bolivia represent 9 linguistic families (Jaqaru of Aymara Quechua, Arawak, Cloth, Guaraní and several isolated ones) with several dialectic forms. They also represent a diversity of historical horizons with respect to the moment and the characteristics of their contact with the dominant society not only during the colonial period but also in the Republic period. While the majority indigenous groups - Quechuas and Aymaras have a colonial relation of 500 years, there are peoples that are only 60 years old, such as the Ayoreo, or that have only 18 years of contact, like Yukí. This high heterogeneity is reflected in a very differentiated cultural system. The social, economic, political and religious structure is quite different among them.

> **Culturally appropriate care:** Although there are important advances in health specific norms with respect to obligatory nature many studies show in the rendering of services, particularly in the case of pregnancy and childbirth an application of the principle of the culturally suitable care in a inter culturality framework that does not exist . A strong presence of discriminatory practices and conceptions towards indigenous populations remains as well as contempt for their cultural forms and practices and their vision of the world.

Inequities

> **Poverty:** The calculation of poverty by NBI does not distinguish indigenous from the non-indigenous populations. Nevertheless, rural municipalities with a high predominance of indigenous peoples, particularly located in the area of the plateau and valleys, present poverty in more than 90% of the homes.

> **Illiteracy:** According to the 2001 census, 19.61% of the indigenous population is illiterate compared to 4,51% among non indigenous ones. Also, one out of three natives is functionally illiterate. By gender, the indigenous men present a rate of illiteracy of 9,87 compared to 2,85 among non indigenous ones. Indigenous women present a rate of illiteracy of 29,03 compared to 6,08 among non indigenous ones.

> **Unemployment:** Those economically active indigenous peoples reach on average of 59,07% compared to 43,94% among the non indigenous one. The unemployed indigenous population is at 2,19% compared to2,35% among non indigenous ones.

> **Utilities:** As no work has been performed with ethnic belonging, there is no data regarding indigenous populations; It can be stated that most of the municipalities presenting a high shortage, have a majority of indigenous population.

> **Infant mortality:** As per the 2001 census, indigenous peoples present infant mortality at 75 per one thousand born in comparison with 52 per 1,000 born in the non indigenous population. In urban areas, the rate of infant mortality of natives is 63 per 1,000 born in comparison with 47 per 1,000 born alive between non indigenous. In rural area, indigenous infant mortality is 94 per 1,000 and non indigenous is 65 per 1,000 born alive.

> **Maternal mortality:** Although there is no data divided by ethnic belonging, partial studies made from the post census survey from the 2001 Census estimate that in the municipalities that present high exclusion levels, the estimated rate is 300 deaths per 100.000 born. All of these municipalities are of Aymara and Quechua heritage.

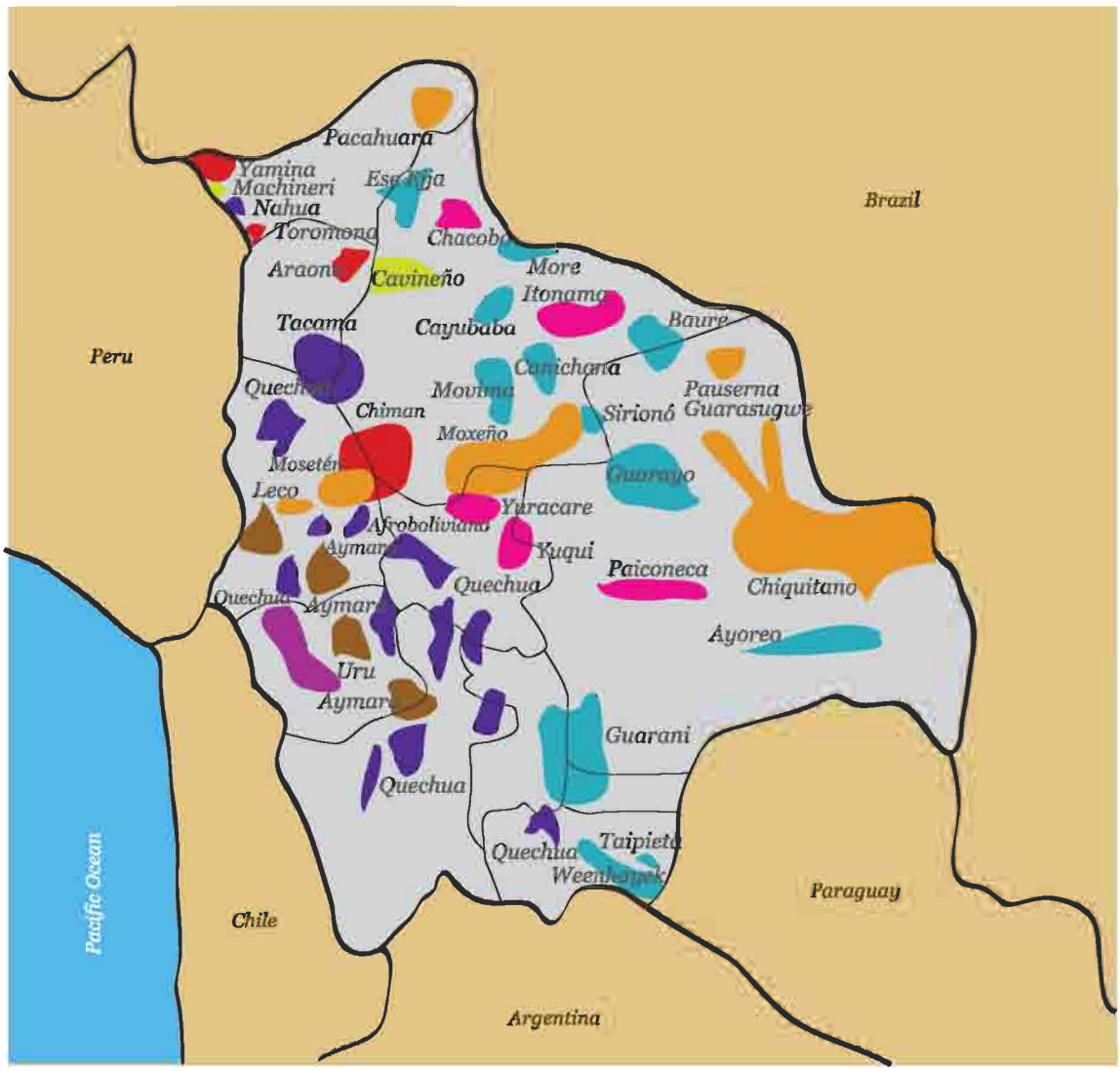
> **Undernourishment:** According to the National Survey of Demography in Health (ENDSA) from 1994, 28% of children of under three years presented chronic undernourishment (deficit of stature for the age). One out of every three children, in rural areas and one out of every five, in urban areas, suffered from chronic undernourishment.
Although there is no information by ethnic belonging, it is possible to state that undernourishment seriously affects the indigenous population because of their majority in rural areas and marginal urban zones of poverty concentration.

> **Infectious diseases:** Chagas disease is present in 60% of the Bolivian territory, in the area of the valleys in which the Quechua population is the majority. Mortality estimated from this disease is 13% of the total population. In three fourths of Bolivian territory, malaria is transmitted and where, this is half of the population or 3,5 millon inhabitants live. In 1999 the National Program for Control of Tuberculosis reported 9,272 cases of tuberculosis in all its forms, a reduction from 132 to 114 per 100,000 inhabitants from 1996 to 1999. Nevertheless, the observed reduction must be interpreted with caution, because it can be associated with changes in the system of notification and registry. In workshops on health with representatives of Indigenous Peoples, the factors that were mentioned as the most frequent causes of death in men are: malaria, diarrhea, tuberculosis, and Chagas. With respect to the causes of death of children, the factors are: diarrhea, undernourishment, pneumonia and dysentery. For women, hemorrhage during childbirth and pregnancy.

> **Diabetes, obesity, alcoholism:** No data by ethnic belonging.

> **Suicidie:** No data by ethnic belonging.

Indigenous peoples of **Bolivia**



Brazil

1. International agreements and national policies (part 1)

International agreements	Legal Framework		Technical units accountable for the Health of Indigenous people	
	Constitution /National Policies	Health Policies	Ministry/ Government instances	Contact Information
WLO Agreement 169 (approved by Decree No. 5.051, of April 19, 2004)[1] Resolution CD37.R5 Resolution CD40.R6	The Federal Constitution acknowledges the ethnic and cultural specificities of indigenous peoples, and lays down their social rights. The main articles 231 and 232 from chapter VIII (About Indigenous Peoples) from Heading VIII (About social order): **Art. 231. Indigenous peoples are recognized by their social order, practices, languages, beliefs and traditions and the original rights upon the land they occupy. The Union being competent for delimiting, protecting and enforcing all their goods.** **1st** The land traditionally occupied by indigenous peoples are those where they live on a permanent basis, those used for productive activities, those indispensable for the preservation of environmental resources that are necessary for their well-being, and those that are necessary for their physical and cultural reproduction. **2nd** The land traditionally occupied by indigenous peoples is dedicated to their permanent settlement, and they are entitled to the exclusive use of the wealth of the land, rivers and lakes within it.	**>National Policy** Decree MS No. 254 of January 31, 2002 approves the National Policy on Health Care for Indigenous Peoples. Decree 070/GM of February 20 2004, approves the guidelines for the Management of the National Policy on Indigenous Health Care. **>Indigenous Health Subsystem** The Indigenous Health sub-system of the Unique Health System was instituted by Law No. 9.836 of September 23, 1999, which added a specific chapter to Law 8.080 of September 19, 1900, which structures the Unique Health System. This Law is regulated by Decree No. 3156 of August 27, 2004. **>Relation with the UHS** Decree MS No.1163 of September 14, 1999, establishes some mechanisms of the relationship of the system with other UHS spheres. **>Special Indigenous Health Districts** Decree FUNASA No.852 of September 30, 1999 creates the Special Indigenous Health Districts and their structure; FUNASA's Internal regiment places DSEIs within the body's structure.	>Indigenous Health Department of the National Health Foundation, a part of the Ministry of Health. DESAI/FUNASA/MS > Sanitation and Building Coordination in Indigenous Areas Public Health Engineering Department of the National Health Foundation - COSAN/ DENSP/FUNASA/MS	> Dr. Alexandre Padilha Address: SAS Quadra 04 Bloco N Sala 702 FUNASA Building Telephone: 55 (61) 314-6356 55 (61) 223-1766 Fax: 55 (66) 226-7149 55 (61) 226-4006 E-mail: Alexandre.Padilha@funasa.gov.br > Lucimar Alves Address: SAS Quadra 04 Bloco N 6o Andar FUNASA Building Telephone: 55 (61) 314-6340 55 (61) 314-6527 Fax: 55 (66) 55 (61) E-mail: lucimar.alves@funasa.gov.br

3rd The exploitation of hydric resources, including energy potential, prospection and extraction of mineral resources in indigenous lands can only be carried out with the authorization of the National Congress, once the communities affected have been heard, ensuring their participation in the extraction results, according to the law.

Art. 232. Indigenous peoples, their communities and organizations are legitimate parties to go to Law to defend their rights and interests, with the intervention of the Public Ministry in all acts of the trial.

> Health Responsibility

The District Chief is the health authority over indigenous territories included inthe DSEI. Article 8 from Decree 3156/99 in its 1st paragraph, creates the figure of the District Chief and paragraph 3 defines DSEI's health responsibility.

> Support, participation and social control

Decree MS No. 70/GM of February 20, 2002 establishes mechanisms for support and social participation, creating the Consultative Council for Indigenous People Health Care Policy and resolution CNS/MS No.293 of the National Health Council of July 8, 1999, which reorganizes the Intersector Indigenous Health Committee.

[1] Covenant 169 of the International Labour Organization (1989) was signed by the following countries: Argentina, Bolivia, Brazil, Colombia, Costa Rica, Dominica, Ecuador, Guatemala, Honduras, Mexico, Paraguay, Peru and Venezuela.

[2] The 35 state members of PAHO expressed their resolution to make issues related to indigenous peoples a priority as found in their endorsement of Resolutions CD37, R5 (1993) and CD40, R6 (1997). The following countries are members of PAHO: Antigua and Barbuda, Argentina, Bahamas, Barbados, Belize, Bolivia, Brazil, Canada, Chile, Colombia, Costa Rica, Cuba, Dominica, Ecuador, El Salvador, the United States of America, Grenada, Guatemala, Guyana, Haiti, Honduras, Jamaica, Mexico, Nicaragua, Panama, Paraguay, Peru, the Dominican Republic, St. Lucia, St. Kitts and St. Nevis, St. Vincent and the Grenadines, Suriname, Trinidad and Tobago, Uruguay and Venezuela.

1. International agreements and national policies (part 2)

International agreements	Legal Framework		Technical units accountable for the Health of Indigenous people	
	Constitution /National Policies	Health Policies	Ministry/ Government instances	Contact Information
		Social control mechanisms are defined for the Unique Health System for laws 8080/90 Art. 7, VIII and law 8142/90. In the indigenous health sub-system, this is regulated by the following rules and provisions: Law 9836/99 Art. 19-H Right to participate in the National, State and Municipal Health councils; > **Decree 3156/99 Art. 3** Paragraph VIII social control > **Decree 3156/99 Art. 8** Paragraph 4 attributions of the District Indigenous Health Council > **Decree 3156/99 Art. 8** Paragraph 5 equal composition of the District Indigenous Health Council > **Decree 3156/99 Art. 9** attributions of the local Indigenous Health Councils. > **Decree 3156/99 Art. 10** Competence for the appointment of council members > **FUNASA Decree 852/99 Art. 3 to 6** institutes District Indigenous Health Councils. > **Decree MS 254/02** (Annex Item 4 and sub items) details the conception of indigenous health councils. > **Decree MS 1163/99 Art. 2** Item III delegates competence to FUNASA to guarantee the participation of indigenous peoples in social control instances.		

2. Strategic Alliances and Interinstitutional and Intersector Cooperation Networks (Part 1)

Agreements	> Since 1999, the National Health Foundation has set up agreements with non-governmental organizations, including indigenous organizations, municipalities and universities for the provision of health services, social control promotion, and training of indigenous health agents to act in indigenous territories. Nowadays, FUNASA has agreements with 49 organizations:

FUNASA agreements with Indigenous Organizations in 2004:

> Tikuna Tribe General Council -CGTT-AM
> Coordination of Indigenous Organizations of the Brazilian Amazon Region - COIAB-AM
> Indigenous People Organization of Medio Purus-OPIMP-AM
> Indigenous Nations Union of Tefé UNI-TEFÉ-AM
> Indigenous Organizations Federation of Upper Black River -FOIRN-AM
> Coordination of Indigenous People Organizations in Ceará-COPICE-CE
> Health Support Association of the KANELA-MA
> Health Association of the Indigenous Community of ARAME-MA Municipality
> Health Association of Indigenous Societies of GRAJAÚ-MA
> Health Association of Indigenous Societies of JENIPAPO DOS VIEIRAS-MA
> Health and Development Association of Indigenous Peoples KATU I'PEJ-MA
> Pyhcopcatjji Health Association -GAVIÃO-MA
> INDIGENOUS COUNCIL PEP'CACHIC-M.ALTOS (KRIKATI)-MA
> Indigenous Development Organization of AMARANTE-MA
> INDY MAHADU-MT Association
> HALITINÃ-MT Association
> Inpre-rê Association for the Defense of the Mebengokre People-IPREN-RE-MT
> Mavutisinin Association -MT
> Indigenous Peoples´ Association of Tocantins - APITO-PA
> Tembé de Tomé Indigenous Association -Açu - AITTA-PA
> Moté Kaipó Charitable Association - ABEMOKÁ-PA
> Indigenous Peoples´ Moté Kaipó of Sur del Pará - APISUL-PA
> Tuto Pombo Association-PA
> PIKATOTI Association KAMOKO-RE-PA
> Roraima Indigenous Council -CIR-RR
> Kanharu Indigenous Association -AIKA-SC
> XERENTE Indigenous Association -AIX-TO
> Indigenous Organizations Coundil of the Javaé People - CONJABA-TO

2. Strategic Alliances and Interinstitutional and Intersector Cooperation Networks (part 2)

Agreements	**FUNASA agreements with NGOs (except indigenous) in 2004:** > Institute for the Support of Self-sustainable Development of Indigenous Peoples -INDASPI-(CASAI)-AM > Institute for the Support of Self-sustainable Development of Indigenous Peoples -INDASPI-AM (Parintins) > Evangelical Mission CAIUÁ-MG > Evangelical Mission CAIUÁ-MS > Institute for the Promotion and Education of the Center and North - IPEC-MT > Native Amazon Operation -OPAN -MT > Roraima Diocese -RR > Brazilian Institute for Health Development - IBDS-RR > Rondonista Association of Santa Catarina -RONDONISTA-SC **FUNASA agreements with universities and research institutions in 2004:** > Brasília University-UNB-DF > Mato Groso Federal University - UFMT-MT > Brasília University - UNB-MT > São Paulo University - USP-MT > São Paulo University -UNIFESP-MT > Brasília University - UNB-RR > Society for the support of Health, Education and Research actions in the State of Tocantins - SASEP-TO **FUNASA agreements with Municipalities in 2004:** > ALTAMIRA-PA Municipality > PARAGOMINAS-PA Municipality > JACAREACANGA-PA Municipality > ENTRE RIOS-SC Municipality > São Paulo Municipal Health Secretariat
National, interinstitutional/ intersectorial projects	> Delimitation of Indigenous Territories, Community Development, Rights Advocacy **NATIONAL INDIGENOUS FOUNDATION - FUNAI/MINISTRY OF JUSTICE** Mércio Pereira Gomes (FUNAI's President) - mercio.gomes@funai.gov.br SEPS Quadra 702/902 Bloco A, Ed. Lex – 3º andar - 313-3502 > **INDIGENOUS SCHOOL EDUCATION** **MINISTRY OF EDUCATION** Kleber Matos - klebermatos@mec.gov.br Esplanada dos Ministérios, Blc. L, 8º andar, fone 410.8434/8520/8543

National, interinstitutional/ intersectorial projects	> **FAMILY AGRICULTURE** **MINISTRY OF AGRICULTURAL DEVELOPMENT** Renata Leyte Manoel de Jesús - renata.leite@mda.gov.br Esplanada de los Ministerios, Blc. A, 8º andar - 314.8005 / 426.9845 > **ENVIRONMENTAL POLICY** **MINISTRY OF THE ENVIRONMENT** Isa Maria Pacheco - luna.rego@mma.gov.br Esplanada de los Ministerios, Blc. B, 5º andar 317.1201/1323/1451 - 317.1080 > **RACE EQUITY PROMOTION** Special Secretariat for Race Equity Promotion Benedito Cintra - benedito.cintra@planalto.gov.br Esplanada de los Ministerios, Blc. A, 315.1816 > **FOOD SAFETY PROGRAMS; REVENUE COMPLEMENT** **MINISTRY OF SOCIAL DEVELOPMENT AND HUNGER FIGHTING** Citizen Rent Secretariat Mônica Aparecida Rodrigues - monicar@planalto.gov.br 325.7867 / 7774 Food Assurance Secretariat 325 7871 > **SCIENTIFIC RESEARCH, HUMAN RESOURCE TRAINING, IMMUNOBIOLOGICAL PRODUCTION** **OSWALDO CRUZ FOUNDATION INSTITUTE – FIOCRUZ/MINISTRY OF HEALTH** > **REGIONAL LABORATORY REFERENCE** **EVANDRO CHAGAS INSTITUTE– BELÉM – PARÁ** **AMAZONIC TROPICAL MEDICINE INSTITUTE– MANAUS – AMAZONES**
Projects of various countries	> **Argentina:** Scientific and Technological Cooperation Agreement; Integration, Cooperation and Development Treaty; Agreement on Technical Cooperation. > **Bolivia:** AAgreement on Health Cooperation; Agreement on Economic and Technical Cooperation. (Roboré Document; Complementary Adjustment to the Basic Agreement on Technical and Scientific Cooperation in the Endemics Control Area; Basic Agreement on Technical, Scientific and Technological Cooperation; Complementary Adjustment to the Basic Agreement on Technical, Scientific and Technological Cooperation for the implementation of the Project for Control and Prevention of Sexually Transmitted Diseases, Human Immunological Deficiency Virus and Acquired Immunological Deficiency Syndrome (DST/HIV/AIDS) in Bolivia, Memorandum of Understanding on the International Cooperation Program of Brazil's Ministry of Health. > **Colombia:** Agreement on Health Cooperation for the Amazon Region; Agreement on the Execution of Technical Cooperation Projects; Basic Agreement on Technical Cooperation; Amazon Cooperation Agreement; Agreement on Scientific and Technological Cooperation; International Cooperation Program for HIV Control and Prevention for Developing Countries. > **Chile:** Agreement on Cultural and Scientific Cooperation; Basic Agreement on Scientific, Technical and Technological Cooperation.

2. Strategic Alliances and Interinstitutional and Intersector Cooperation Networks (part 3)

Projects of various countries	> **Costa Rica:** Agreement on Health Cooperation, Agreement on Technical Cooperation; Complementary Adjustment to the Agreement on Technical Cooperation in the Health Area. > **Cuba:** Basic Agreement of Scientific, Technical and Technological Cooperation in Health issues and several intention protocols (family health, oral health, education). > **El Salvador:** Agreement on Technical, Scientific and Technological Cooperation; Complementary Adjustment to the Agreement on Technical, Scientific and Technological Cooperation for the implementation of the project "Support to the Sexually Transmitted Disease and AIDS Program; International Cooperation Program for HIV Control and Prevention for Developing Countries; Complementary Adjustment to the Agreement on Technical, Scientific and Technological Cooperation for the Implementation of the Project for Care and Treatment for People with AIDS in El Salvador. > **Ecuador:** Basic Agreement on Scientific and Technological Cooperation; Complementary Adjustment to the Basic Agreement on Technical Cooperation for the implementation of the Project: "Amazon Cooperation for Local Skill Building"; Complementary Adjustment to the Basic Agreement on Technical Cooperation for the implementation of the Project "Strengthening Response Capability to the Program for the Prevention and Control of Sexually-Transmitted Diseases, Human Immunological Deficiency Virus and Acquired Immunological Deficiency Syndrome (DST/HIV/AIDS) of Ecuador, Intention Protocols in Health; Complementary Adjustment to the Basic Agreement on Technical Cooperation for the implementation of the Project Exchange to strengthen National Health Systems of Brazil and Ecuador. > **USA:** Agreement on Technical Cooperation in Health; Cooperation Agreement in Science and Technology for Biological Control of Aedes Aegypti Mosquito > **Guatemala:** Basic Agreement on Scientific and Technical Cooperation > **Guyana:** Health Cooperation Agreement; Basic Agreement on Technical Cooperation; Amazon Cooperation Agreement; Friendship and Cooperation Treaty; Protocol of Intention in Health > **Haiti:** Agreement on the creation of the Brazil-Haiti Mixed Commission > **Honduras:** Basic Agreement of Scientific and Technical Cooperation > **Jamaica:** Technical Cooperation Agreement > **México:** Basic Agreement on Technical and Scientific Cooperation; Agreement on Animal Health; Friendship and Cooperation Agreement > **Nicaragua:** Basic Agreement on Technical Cooperation; Protocol of Intention (Health) > **Panama:** Basic Agreement on Scientific and Technical Cooperation > **Paraguay:** Agreement for Exchange of Technicians between both countries; Health Agreement; Technical Cooperation Agreement; International Cooperation Program for HIV Control and Prevention for Developing Countries. > **Peru:** Census Agreement; Health Agreement, Basic Agreement on Scientific and Technical Cooperation; Agreement for the constitution of a Brazilian-Peruvian mixed sub-commission for the Amazon Region; Agreement on Health for the Tropical Environment. > **Suriname:** Basic Agreement on Scientific and Technical Cooperation

Projects of various countries	> **Uruguay:** Basic Agreement on Scientific and Technical Cooperation; Agreement on Health Cooperation, Complementary Adjustment to the Agreement on Technical, Scientific and Technological Cooperation for Health at the National Border > **Venezuela:** Basic Agreement on Technical Cooperation; Agreement on Border Health Cooperation; Agreement for Notes Exchange, enforcing the Internal Regulation of the Border Affairs Committee, created during the I Extraordinary Meeting of Brazil-Venezuela Consular Cooperation Group. The information above is available and details can be requested at http://www2.mre.gov.br/dai/bilaterais.htm.
Interinstitutional / Intersectorial Fora	> **NATIONAL CONFERENCE ON INDIGENOUS PEOPLES HEALTH** Thematic Conference, integral part of the National Health Conferences, created by Law 8.142 of December 28, 1990. It is carried out every four years and it is the maximum board of social control. It has a deliberative nature, equal composition between users and service providers/health workers. > **NATIONAL HEALTH COUNCIL** Created by Law 8.142 of December 28, 1990. It has an indigenous representative appointed by the Indigenous Health Intersector Commission. Deliberative for the Unique Health System. > **INDIGENOUS HEALTH INTERSECTOR COMMISSION** Resolution CNS/MS No.293 of the National Health Council of July 08, 1999. Permanent Consultative Committee of the National Health Council – CNS. > **CONSULTATIVE COUNCIL OF THE HEALTH CARE POLICY FOR INDIGENOUS PEOPLES** Decree MS No. 70/GM of February 20, 2002. It has a consultative nature, equal composition between users and service providers/health workers. > **DISTRICT INDIGENOUS HEALTH COUNCILS** Created by Decree 3156 of August 27, 1999. Deliberative (Decree MS 254 of January 31, 2002), of equal composition between users and service providers/health workers. > **LOCAL INDIGENOUS HEALTH COUNCILS** Created by Decree 3156 of August 27, 1999. Consultative for the District Council, majority composition of members from the indigenous communities they are connected with. > **STATE AND MUNICIPAL HEALTH COUNCILS** Law 9.836 of September 23,1999 allows the participation of indigenous peoples in these associations for the design, follow-up and evaluation of health policies. It has a deliberative nature, equal composition between users and service providers/health workers.
Indigenous organizations that include the health approach in their political agendas.	In Brazil, the Federal Constitution guarantees practices and traditions of indigenous peoples. Thus, the entire Brazilian indigenous movement is guided by the recovery of differentiated public policies and culturally appropriate. Since 1999, the National Health Foundation has entered into agreements with non-governmental organizations, including indigenous organizations, municipalities and universities for the provision of health services, social control promotion, and training of indigenous health agents to act in indigenous territories. Nowadays, there are indigenous organizations that have agreements with FUNASA.
Networks	Indigenous Health Network of the Amazon Region - RED SIAMA - www.redsiama.org

3. Primary health care and interculturality (part1)

Policies that promote the incorporation of the perspectives, indigenous medicine and therapies into National Health Programs.	All Brazilian legal mechanisms promote respect and inclusion of traditional therapeutical perspectives > **FEDERAL CONSTITUTION, ART. 231** ***Indigenous peoples are recognized their social order, practices, languages, beliefs and traditions, and the original rights upon the land they occupy.*** **Act 8.080/90 of the unique health care system, Articles 19 A to 19 H (Modified by Act 9.836/99)** The Indigenous Health Care Sub-system is instituted, being a component of the Unique Health System – SUS. The sub-system will be based on the Special Indigenous Health Districts. The SUS will be a rearguard and reference for the Indigenous Health Care Sub-system, which may require looking for adaptations in SUS structure and organization in regions where indigenous peoples live, in order to favor that integration and the necessary attention at all levels, without discrimination. Indigenous peoples must have guaranteed access to the SUS, at the local, regional and specialized center level, according to their needs. Indigenous peoples will have the right to participate in associated bodies for the design, follow-up and evaluation of health policies, such as the National Health Council, the State and Municipal Health Councils, when appropriate. > **DECREE 3.156/1999** Art. 2. For compliance of the above provision, the following guidelines shall be followed for the promotion, protection and recovery of indigenous health, analyzing the scope of biopsychosocial balance, recognizing the value and complementarity of indigenous medical practice, according to the particular characteristics of each community, epidemiological profile and health condition: VIII – the participation of indigenous communities involved in the design of indigenous health policy, its programs and implementation projects; and IX – the acknowledgement of indigenous social and political organization, practices, languages, beliefs and traditions. Single Paragraph. The organization of health care activities for indigenous populations will take place within the framework of the Unique Health System, and will become effective in a progressive manner through the Special Indigenous Health District, ensuring basic care services within indigenous territory. > **Ministry Decree No. 254/2002 of the Ministry of Health** Approves National Policy on Indigenous People Health Care. Its guidelines include: > preparing human resources to act in an intercultural context; "Training indigenous people as health agents is a strategy that aims at benefiting indigenous peoples with the appropriation of knowledge and technical resources of western medicine, not as a substitute, neither to add to their own therapies and cultural practices, be they traditional or not. The Training Program of Health Indigenous Agents shall be conceived as part of the building process of Special Indigenous Health Districts. It will be developed as a service and in a continuous manner, under the responsibility of Instructors/Supervisors, duly trained, with the cooperation of other health care professionals and the leadership and indigenous organizations. The training process of indigenous health agents will be prepared within the framework of the Law of National Education Guidelines and Foundations – LDB (Law nº 9.394/96), concerning basic training, aiming at building competences/skills, facilitating the professionalization at middle (technical) and higher (technological) level. It should follow a participative methodology, appropriate for intercultural communication, in order to benefit the reciprocal process of knowledge acquisition.

Policies that promote the incorporation of the perspectives, indigenous medicine and therapies into National Health Programs.	Existing socio-anthropological studies and those carried out in a participative manner should be taken as subsidies to the training of human resources and the provision of services itself. The body that is responsible for the execution of health care actions for indigenous peoples will work to obtain certificates of competences for the agents, with the support of the competent education bodies and institutions, even for those already trained, according to Law nº 9.394/96. Human Resource Training for indigenous health must be prioritized as a fundamental instrument for making suitable the actions of SUS health professionals and services to the specificities of health care for indigenous peoples and the new technical, legal, political and organizational reality of services. Update, perfectioning and specialization courses should be promoted for health professionals and technical advisors (indigenous and non-indigenous) of the numerous institutions acting within the system." **> Articulation of the traditional indigenous health systems;** "The underlying principle of all guidelines of the National Policy on Health Care for Indigenous Peoples is respect to conceptions, values and practices relative to the health-disease process, that belong to every indigenous society and their different specialists. The articulation with this knowledge and practices must be stimulated for improving health conditions of indigenous peoples." **> MINISTRY DECREE no 1.163/1999 OF THE MINISTRY OF HEALTH** Art. 2 Set up the following attributions of the National Health Foundation, in relation to the health of indigenous peoples: I – to promote the implementation of Special Indigenous Health Districts - DSEI, with the purpose of facilitating access of indigenous peoples to basic health actions and services, taking into consideration the following aspects: a) the organization of each district should be extended as a process to be built with the participation of indigenous peoples, observing their own concepts and practices related to their living and dying conditions. Art. 5 To institute the Incentive Factor of Basic Care for Indigenous Peoples, dedicated to actions and procedures of Basic Health Care. § 1º The incentive referred in this article consisting of the amount of resources assigned to support the implementation of indigenous health agents and multidisciplinary teams for health care of indigenous communities. Art. 7 Create the Incentive factor for outpatient, hospital and diagnosis support care for indigenous population. Single paragraph: The caput incentive factor of this article will be aimed at hospital facilities that consider the specificities of health care for indigenous peoples and that offer them health care in their own territory or region of reference.
Harmonization experiences of indigenous and conventional health systems	**> BASIC HEALTH CARE IN INDIGENOUS LANDS/TERRITORIES** Basic care is guaranteed in indigenous lands through Special Indigenous Health Districts for average and high complexity health care in the network of services of Municipalities and States, with support and differentiated care mechanisms **> INDIGENOUS HEALTH CENTERS** Promote supporting services to patients directed by the Unique Health System network. These Health Centers should be in proper conditions to receive, house and provide food to directed patients and companions, to provide nursing care 24 hours a day, make appointments, complementary examinations and hospital admission, make provisions for companions of patients in these cases and their return to their original communities, supported by the corresponding information. **> TRADITIONAL INDIGENOUS MEDICINE PROGRAM – VIGISUS/FUNASA PROJECT** Promotion of Research and Studies in the area of traditional indigenous medicine, of institutional interest and indigenous groups; Constitution of the Monitoring Center for Traditional Indigenous Medicine; Documentation and dissemination of the MTI articulation process to the official health system; Promotion of indigenous leading role in the MTI articulation process and dialogue between social stakeholders;

3. Primary health care and interculturality (part 2)

Harmonization experiences of indigenous and conventional health systems	**> COMMUNITY INITIATIVES FUND - VIGISUS/FUNASA PROJECT** Financial support for research and preparation of community intervention projects related to traditional indigenous medicine. The purpose of this strategy is the recognition and strengthening of traditional medical systems and the encouragement to the leading role and autonomy of indigenous stakeholders. The support for the preparation of community projects will be provided by technicians from the Districts involved and trained to act in that area. **> PROJECT "RECOVERY AND DISSEMINATION OF MEDICINAL HERBS IN FULNI-Ô (PE) POPULATION"** in order to "contribute with Fulni-ô people's health, with the recovery and use of the medicinal plants in traditional practices of the indigenous culture". It includes building a pharmacy for the manipulation of medicine production from traditional medicinal plants **> INTEGRATION OF INDIGENOUS MIDWIVES INTO INDIGENOUS WOMEN'S CARE** In Acre State, the Indigenous Nations Union for Acre and South of the Amazons (UNI-Acre), working with the Munipal Health Secretariat, proposed the integration of indigenous midwives into indigenous women's care, as a strategy for the interaction of knowledge and traditional practices, which are important for care quality of women's health. **> Intervention in the issue of alcoholic beverage abuse by spiritual leadership and cure experts** In Rio Grande do Sul, with the Participative Anthropological Diagnosis on Alcoholism, which started in 2000, cure and spiritual leader specialists came to develop intervention activities concerning the abuse of alcoholic beverages, using resources available for traditional medicine: advice with "good words". As a result of social mobilization, a reduction of collective moments to have alcoholic beverages (White parties) was observed and as consequence, the number of domestic violence cases related to them decreased. **> TRAINING OF INDIGENOUS HEALTH AGENTS** Since 2000 to 2003, 3376 indigenous health agents (AIS) were trained through a constructivist methodology, with concentration and dispersion stages. Out of this group, 1965 AIS followed the course on Endemic Diseases; 499 AIS followed the course on Sexually-transmitted Disease and AIDS, 170 followed the course on intestinal parasitoses and skin diseases and 878 followed the course on Women and Children Health and Oral Health. In order to guarantee the support to health actions in Indigenous Areas, in 1999 the National Health Foundation, through the Public Health Engineering Department – DENSP -, proposed the Training Program for Indigenous Health Agents – AISAN – with the purpose of preparing indigenous people for the operation and maintenance of water supply systems, besides other complementary activities in alliance with the Indigenous Health Agent – AIS -, such as development of the health education process in their village, in order to contribute to improve the community's quality of life and reduce the index of morbimortality due to diseases of hydric vehiculation. 630 AISAN were counted acting in all Brazilian regions, trained during the 2000-2003 period. **> INCENTIVE FOR HIGHER EDUCATION OF INDIGENOUS PEOPLE IN HEALTH, SOCIAL AND SIMILAR SCIENCES - VIGISUS/FUNASA PROJECT** During the 2005-2007 period, FUNASA through its VIGISUS Project, aims at supporting higher education in health and human sciences for indigenous people by means of a program of 30 scholarships, to respond to spontaneous demand. The Ministry of Education has encouraged the concession of "special places", affirmative policy for granting places in public universities for social groups that historically have not had access to higher education. Thus, Decree 4876 of November 12, 2003 was enacted, creating the Program Diversity in University, inserted within the field of the Ministry of Education. In some universities, there are higher education programs for indigenous people, with a focus on pedagogy (UFRR, UFMT) and social sciences (UFAm). Several universities in the country have quota systems for ethnical minorities with specific selection systems (Federal Universities of Mato Grosso, Brasilia, Roraima, Amapá and Maringá and Ponta Grosa states, etc.). **> SPECIALIZATION IN INDIGENOUS HEALTH** There are specialization programs in indigenous health by initiative of several universities in the country. (UFAm, UFMT, FIOCRUZ etc.).

4. Information, analysis, monitoring and management (part 1)

Information about demographic, socioeconomic and epidemiological profiles of indigenous peoples.	> **YAMAMOTO**, Renato (Org.) – Manual on Brazilian indigenous children Health Care. Brasília: National Health Foundation, 2004. Promoted by the Brazilian Pediatrics Society. Available on the web at http://www.funasa.gov.br/sitefunasa/pub/pub00.htm. > **COIMBRA JR.,** Carlos (org.) – Epidemiologics and health of indigenous peoples in Brazil. Rio de Janeiro: Ed. FIOCRUZ / ABRASCO, 2003. > **GARNELO,** Luíza et alli – Indigenous Peoples and the building of health policies in Brazil.. Brasília: Pan-American Health Organization, 2003. > **BRASIL. MINISTÉRIO DA SAÚDE. FUNASA** – Morbimortality Report 2002. Brasília: National Health Foundation, 2003. > **RICARDO,** Carlos Alberto – Indigenous Peoples in Brazil 1996/2000. Brasília: Socioenvironmental Institute, 2000. > **CUNHA,** Manuela (org.) – History of Indigenous Peoples in Brazil. São Paulo: Companhia das Letras/Sec. Municipal de Cultura/FAPESP, 1992.
Information, monitoring and evaluation systems of indigenous peoples' health, including the ethnic variable.	> Official systems in Brazil include a color/race variable, where "indigenous" is a generic option. > Information systems of the Unique Health System include Color/Race but not the ethnic variable. The interconnection of both systems to the indigenous health system, SIASI. > Information system of Indigenous Health Care – SIASI from SUS includes the ethnic variable.
Maps of indigenous peoples in countries, according to their political division (includes map in the annex)	> See map attached. *(page. 78)* For general information on Indigenous Peoples in Brazil www.funai.gov.br www.socioambiental.org/ website/pib/portugues/quoncua/cadapovo.shtm

4. Information, analysis, monitoring and management (part 2)

Characterization of indigenous peoples, concerning their life and health conditions, social organization and belief and value systems, which influence health maintenance and recovery.	Nowadays, Brazilian indigenous population reaches about 411 thousand people (see population by age group and sex and population pyramid below) belonging to almost 210 peoples, who speak more than 170 different languages, with different social organization, aspects that should be considered in the promotion of health care actions. For a differentiated health policy for indigenous peoples to become effective, the Indigenous Health Subsystem is based on the Special Indigenous Health Districts. The territorial definition of Special Indigenous Health Districts shall take into consideration the following criteria (Decree MS 252/2002): > Population, geographic area and epidemiological profile; > Availability of services, human resources and infrastructure; > Access routes to services set up at local level and to the SUS regional network; > Social relationships between the different indigenous peoples of the territory and the regional society; > Traditional demographic distribution of the indigenous peoples, that does not necessarily coincide with the limits of states and municipalities where the indigenous peoples are located.
Periodical publications about health of indigenous peoples	FUNASA in Revista, Biannual Publication of the National Health Foundation
Section on health of indigenous peoples on the website of the Ministries of Health, PAHO and other institutions (e-mail address)	> NATIONAL HEALTH FOUNDATION http://www.funasa.gov.br http://www.funasa.gov.br/sitefunasa/ind/indoo.htm > NATIONAL HEALTH COUNCIL http://conselho.saude.gov.br/ http://conselho.saude.gov.br/comisao/saudindio.htm

Second part

1. What were the most relevant results in the health care of indigenous peoples between the period 1995-2004?

> Guaranteeing indigenous peoples' rights in the Federal Constitution allowed the institutionalization and incorporation of several specific mechanisms and the creation of a Unique Health Sub-system: the Indigenous Health sub-system.

> In 1999, the transfer of health responsabilities within the field of the Ministry of Justice, where the National Indian Foundation belongs, to the Health Ministry guaranteed a higher professionalization of services and an increasing articulation with actions and strategies adopted in the Unique Health System. It also guaranteed the adoption of financial incentives and an important increase of investment in indigenous health, both in actions of activity cost and investment in equipment and works. The water supplies for indigenous land were highly increased.

> The creation of Special Indigenous Health Districts has been a progress applauded by the indigenous, health movements, becoming an efficient way to guarantee the decentralization of actions, control and social participation and differentiated health care for indigenous peoples.

> The reduction of infant mortality has been relevant From 1998 on, there was a constant reduction of infant mortality indicators, from 96,8/1000 born alive in that year to 55,7/1000 born in 2002 and 43,35/1000 born in 2003 (indicators that are still rather high in comparison to the national index of 27/1000 born alive in 2003.

> Reduction of the General Mortality Coefficient, from 3,8 deaths per 1000 inhabitants in 1993 to 12,8/1000 in 1998 and reached 3,3/1000 in 2003. We observed that health information for the 1993-1995 period was precarious and for the 1996-1998 period, it was almost nonexistent. Setting up DSEIs changed this picture, which allowed the construction of a series of health indicators from 1999 on.

> The implementation of the National Policy on Indigenous Health Care by the National Health Foundation since 1999 represented a leap in the quality and the quantity in terms of an expansion of HR working with indigenous health. In July 2004, there were 10.051 professionals working within the field of the DSEI, 1.517 were hired directly by FUNASA, 4.955 were hired by entities that have agreements with FUNASA, 3.335 contracted by municipalities with resources from the Incentive for Basic Health Care of Indigenous Peoples of the Ministry of Health, 336 connected by municipalities and 358 with other types of links. Today, 389 doctors, 559 nurses, 15 social workers, 8 nutritionists, 127 other higher education professionals, 1960 technicians and nursing assistants, 39 technicians of Oral Hygiene, 64 lab technicians and 176 microscopists (indigenous microscopists are acting directly in indigenous health care in Brazil, linked to the DSEI). The number of Indigenous Health Agents was about 1.400 people in 1998, which increased to 3.665 in 2004, while 573 Indigenous Health Agents are also added here.

2. What are the priority problems of health care of indigenous peoples in the country, at the national and sub national levels?

> Developing structuring actions, of economic sustainability, is an determinant

> It is necessary to strengthen food safety policies and their extension to reach all regions having unsafe food.

> It is necessary to develop a policy on environmental protection and recovery in indigenous areas and influential area. It is also necessary to be effective in actions in order to protect the integrity of indigenous lands (prevention and correction of invasions by third parties).

> The consolidation of Special Indigenous Health Districts should be promoted as management units and the Federal health authority, building human resource

> The consolidation of Special Indigenous Health Districts must be promoted as federal management and health authority units, constituting human resource groups with the necessary technical capacity. A policy on human resources for indigenous health must be built, defining the objective of reducing the high turnover of professionals and the continuity of programs for the development of professional competences at the DSEI.

> A greater articulation of official health services with traditional indigenous health systems must be sought. All human societies have their own interpretation systems and disease treatments. Those traditional health systems are still today the main health care resource for indigenous population, despite the presence of occidental health structures. As part of the culture, those systems condition the relationship of individuals with health and disease and influence the relationship with services and health professionals (the availability of health services, the acceptability of health actions and projects, and the understanding of education messages on health) and the interpretation of disease cases.

> This challenge is to make sense of promoting interculturality in health, with the understanding, acceptance and articulation of therapies by health professionals, as well as in the sense of valuing and strengthening traditional medicine.

> Humanization of indigenous health care with an institutional reform of Indigenous Health Centers – CASAIs, development of reception and risk evaluation of the indigenous patient, construction of therapeutical projects customized to health needs; recognition and valorization of the autonomy of individuals; physical restructuring of health units, contracts with health units that receive financial incentives (including regulation, appointment centers and procedures, responsibility concerning therapeutic projects, etc.).

3. What are the aspects to be considered in the "insertion" of indigenous peoples' health as a priority in the processes the country is promoting to renovate the Primary Health Care Strategy and to fulfill the Millennium Goals Development?

> Due to its small extension and great ethnic variety, besides being in a situation of high inequity, indigenous populations are highly vulnerable. Actions should be intensified in areas of maternal health, infant mortality and vulnerability to DST/AIDS and other diseases. This necessity can not be separated from the guarantee of economic sustainability and integrity of indigenous territories.

Strategic Analysis	
Strengths: the country's particular characteristics that facilitate actions to favor health improvement of indigenous peoples.	**Weaknesses:** Negative aspects inside the country that would make difficult actions to favor health improvement of indigenous peoples.
> Institutionalization of indigenous rights. > Indigenous movement organized and working. > Existence of decentralized services in the 34 Special Indigenous Health Districts. > Existence of different social control instances.	> **Intersectoriality.** The segmentation of Actions in Government bodies has caused contradictory policies. It is necessary to realize about intersectoriality, which could take place through the use of computerized databases. Health, Food Safety, Agriculture, Family Agriculture, Environment, Education, settlement and Agricultural Reform are similar sectors, whose decisions have a direct impact on the national policy about indigenous health. In different parts of the country, there are problems with the social unstructuring of indigenous communities and groups. For instance, extreme exists in of some groups living in urban and peri-urban space, internal violence due to factors such as the presence of miners, wood or toxics traffic, the limitation of indigenous territory, etc. It is extremely urgent to identify the populations at risk and to promote joint efforts to minimize these dangers. Likewise, a close articulation is necessary to avoid divergences in orientation and to promote joint professional training for state agents, contracted agents and workers. > **Human Resources.** Health districts do not have any conditions to exercise their roles as managers and health authorities in indigenous territories, both due to the lack of effective personnel in FUNASA's team and to the deficient training for management. The main problems for health professionals acting in indigenous areas are: high turnover of professionals, shortcomings in some categories, diversity of contracting institutions and contracting criteria, lack of preparation of the manager and the user in the selection of professionals, lack of professionals with a profile for working with indigenous populations, deficiencies in training for the specificity of the job, differences in remuneration among regions.

Análisis Estratégico	
	> **Infrastructure** *(Communication and Transport).* Some regions inside the country are completely lacking basic social equipment and infrastructure. A survey of strategic investment to favor indigenous communities and rural and river populations could be interesting if the social impact of measures could be correctly assessed.
Opportunities. Factors that exist in the context and are considered to facilitate actions that favor the health improvement of indigenous peoples.	**Threats.** Negative factors that could affect the implementation of actions that favor health improvement of indigenous peoples.
> **Intersectoriality.** The Government of Luís Inácio Lula da Silva has promoted a favorable climate of articulation of government actions, signing an agreement on Technical Cooperation between different Ministries with the participation of indigenous peoples. > **Information Systems.** The inventory of a great part of the population and indigenous communities carried out by FUNASA/MS in computerized systems SIASI and SISABI make it possible to integrate and develop of specific functionalities for different areas of the Government. The inexistence of a governmental database of indigenous communities makes it impossible to rely on a coherent evaluation of the problems and it facilitates duplicity of efforts and actions.	> Possibility of discontinuity of investments and no budget guarantee. > Non realization of social control . > Possibility of inefficient performance in crossed policies such as environmental, of economic sustainability, education, infrastructure, etc. > Existence or regional economic projects that impact the ecosystem of indigenous lands.

Third part

Table 1. Population and indigenous peoples of Brazil (population in thousands of inhabitants)

Population	National Population	Indigenous Population	%	Number of Peoples
Less than 1%	169.799.170	426.920	0,25	210

Source: BRASIL - IBGE, 2004; FUNASA, 2004; FUNAI 2003.

Table 2. Challenges, factors to be considered and inequities (part 1)

Challenges

Health and Public Health Strategies should embrace and focus structural and risk factors, as well as get involved in the strong points or strengths of indigenous peoples:
National Health Policy for Indigenous Peoples considers the following guidelines, which should orient the definition of instruments for planning, implementing, evaluating and controlling actions:

> Organization of health care services for indigenous peoples as Special Health Districts and Base-Poles, at local level, where primary care and reference services are located.;
> Preparation of human resources to act in an intercultural context;
> Monitoring health actions addressed to indigenous peoples;
> Articulation of traditional indigenous health systems;
> Promotion of the adequate and rational use of medicines;
> Promotion of specific actions in special situations;
> Promotion of ethics in research and health care actions involving indigenous communities;
> Promotion of healthy environments and indigenous health protection;
> Social control

Factors to be considered

> **Location:** There are indigenous peoples in all Brazilian states, except in Piauí and Rio Grande do Norte, living in 579 indigenous lands, occupying almost 12% of the national territory. Approximately 60% of the indigenous population lives in the West Center and North of the country, where 98,7% of indigenous land is concentrated. The remaining 40% of the population are located only in 1,3% of the territory assigned to indigenous people, who are located in the Northeast, West Center, Southeast and South of the country.

> **Ethnic and Cultural Heterogeneity:** Nowadays Brazilian indigenous population consists of 429 thousand people belonging to about 210 peoples, who speak more tan 175 different languages with different social organization forms, aspects that should be considered for the promotion of health care actions.
Besides their social, symbolic and cultural differences, indigenous groups also differ in what they say about time and historical experience in relation to colonization and expansion fronts of the national society. There are groups with more than three centuries of contact as well as groups with less than ten years. Mining, wood extraction and agricultural activities, plus the lack of guarantee in great part of the indigenous territory, as well as the intense exchange of people between cities and villages put indigenous communities under different vulnerability situations.

Table 2. Challenges, factors to be considered and inequities (part 2)

Nowadays, there has been demographic growth among Brazil's indigenous peoples, which is frequently associated with environmental conservation efforts, the stabilization of relationships between ethnics, delimination of indigenous territories and improvement in access to basic health care services. However, the morbility profile is stressed by a high incidence of acute breathing and gastrointestinal infections, malaria, tuberculosis, sexually-transmitted diseases, malnutrition and diseases that can be prevented by vaccines. In regions where the indigenous population has a close relationship with non indigenous communities, new diseases have appeared because of changes in lifestyle. For instance, high blood pressure, diabetes, cancer, alcoholism, depression and suicide are increasingly frequent. Therefore, the health picture is characterized by the occurrence of health problems that can be significantly reduced with the adoption of systematic and continuous prevention and basic health care measures.

> **Culturally suitable care:** The main problems concerning professionals who act in indigenous areas are high turnover, shortcomings of profiles in some categories, diversity of contracting institutions and contracting criteria, lack of preparation of the manager and users for the selection of professionals, lack of professionals having a profile to work with indigenous populations, training deficiencies for the specificities of the job, and differences in remunerations among regions.

A National Policy on Human Resources for indigenist performance is also needed in the health field, defining a specific career, flexible contracting conditions to allow the selection of suitable profiles, resignation of professionals not adapted to the service, quick selection of professionals and immediate replacement of vacancies.

Inequities

> **Poverty:** IIn Brazil, 38% of the indigenous population is considered extreme poverty (family per capita income below ¼ of the minimum salary) while in non indigenous population the percentage is 15,5%. The Indigenous situation is regionally heterogeneous. In the Northern and Center-Western regions, 62% and 31% respectively of indigenous populations are under extreme poverty, while this is lower for non-indigenous populations in the same regions (25% y 9%).

When comparing poverty percentages of indigenous and non-indigenous populations in big regions, it can be observed that the percentage of poor indigenous people is always higher than for non-indigenous populations. In regions where the rural population is greater, the number of indigenous people who earn an income below ¼ the minimum salary is also greater.

The income pattern for the indigenous population is similar or more precarious than for the most unprotected populations of the Brazilian society. The percentage of indigenous people who earn an income below ¼ m.s. in rural homes is 64% in Brazil, while the ratio decreases for urban poverty (15%). In other words, 2/3 of "rural indigenous people" are under extreme poverty.

Extreme poverty among indigenous people is double the rate of the rest of the population. However, national averages undercover important regional heterogeneities: In the Northeast, poverty level among indigenous and non-indigenous people is similar (36,4% and 30,4%); In the West-Center region, indigenous poverty is almost 4 times higher in the South it is 3 times higher; in the Southeast is double. (SILVA, Frederico et all. – "Diagnosis of indigenous people situation in Brazil". Brasília : IPEA, 2004)

Table 2. Challenges, factors to be considered and inequities (part 3)

> **Illiteracy:** Concerning the situation of formal education, indigenous societies have a big challenge ahead in relation to their organization, extension and necessary care for the respect of differences and different cultural traditions. Table 8 shows that the average number of study years for indigenous populations is lower (4,4) than for the rest of the ethnical groups. The average years of study for black people are 5 and for white people 7.

Illiteracy rates are another indicator that show ethnical inequities. 26% of the indigenous population above 15 is illiterate, while 20% of the black population and 8% of white population are in the same situation. In the Northeastern region, the illiteracy rates of indigenous people is lower than for black people, and very close for white people. Illiteracy is 3 times higher among indigenous people as compared to the white population. There are also important regional differences in this respect.

Concerning education, 45% of indigenous people older than 15 have up to 3 years of study, 37% completed fundamental education and 13,5% middle-level education while barely 2,7% reached 3rd. grade. Regions also have uneven education levels. (SILVA, Frederico et all. – ""Diagnosis of indigenous people situation in Brazil". Brasília: IPEA, 2004).

> **Unemployment:** There are no statistics about unemployment among indigenous peoples. It is known that there is scarce insertion in the labor market as under-employed, temporary workers or producers of godos to be sold in regional markets, almost always work under disadvantageous conditions.

> 2.362 indigenous communities surveyed by FUNASA (March 2004), when asked about the activities they performed for commercial purposes:
> 1158 produced and sold handcrafts
> 743 produced flour
> 298 raised chicken and produced eggs
> 263 raised bovine cattle or goats
> 158 raised pigs
> 119 had irrigated agriculture
> 80 had beekeeping
> 54 grew fish or crustaceans
> 33 had plant nurseries
> 912 had other activities

Utilities: A research on 2.362 indigenous communities (March 2004) showed that (Source: SISABI/FUNASA, 2004):

> 866 have a health center
> 265 have a place at the FUNAI,
> 287 have some sort of commercial establishment
> 1.213 do not have electric energy systems
> 570 have an electric network
> 515 have diesel or fuel generators
> 175 have sun energy
> 224 have aircraft landing area
> 546 are organized into indigenous associations
> 1.421 have schools
> 1056 do not have a phone system
> 1022 have a radio transceiver
> 224 have a fixed telephone
> 207 have a mobile telephone

In a universe of 3.442 villages, 732 are villages served with water supply systems (more than 283 are being built). The expectation is to reach about 2350 villages with water supply systems until 2006 (FUNASA, 2004).

> **Infant Mortality:** In 1998, for 16 (35,6) Funai administrative units, the average rate of infant mortality reached 96,8 per 1.000 born alive, practically one death during the first year of life for each group of ten born alive. Since then, the infant mortality rate has dropped at an average annual rate of 10,6% in relation to 1998, when it reached 96,8 death per 1000 born alive, 55,7/1000 in 2002 (varying from 17,8/1000nv in DSEI Ceará to 185,2/1000nv in DSEI Médio Purus) and 43,35/1000 born alive in 2003. This is certainly associated to the improvement in direct assistance to Brazilian indigenous communities with a considerable reduction of the decurrent obituary, especially infectious diseases such as diarrhea. (FUNASA, "Morbimortality Report 2002-2003"; FUNASA, 2004). Infant mortality rate in Brazil was 27,8/1000 born alive in 2002 and 27/1000 born alive in 2003.

Table 2. Challenges, factors to be considered and inequities (part 4)

> **Maternal Mortality:**

> **Malnutrition:** In relation to nutritional conditions, there is no consolidated profile, especially for Brazil's indigenous populations. In national studies, such as the National Study on Family Expenditure (ENDEF, 1975) and the National Research on Health and Nutrition (PNSN, 1989), indigenous peoples were not included. Existing studies do not establish minimum indicators, such as life expectancy at birth or national or regional prevalence of infant malnutrition, but they point out big nutritional problems of different groups and regions, indicating precarious situations when compared to other segments of national society.

In general, results aim at high frequencies for height deficit for the age (under -2 scores z), which is interpreted as a malnutrition indicator. For the Brazilian population, data from the National Research on Demographics and Health (PNDS\1996) show a 10,5% prevalence of small height for the age for children under five years old, which is opposed to the values observed in indigenous children, according to the studies carried out.

It is estimated that in Brazilian population, every ten pregnant woman who do pre-natal, three of them have anemia, reaching 50% in children (Arruda, 1995).

A study carried out among Xavantes de Sangradouro identified that 48,3% of men and 62,9% of women examined were diagnosed with anemia (Leyte, 1998). Prevalence varied significantly with age, with the highest figure for children under ten (73,7%), from 10 to 15 years old (63,6%) and women from 20-40 years old (54,2%) (Leyte, 1998).

Among the Tupi-Mondé, about 60% of the children from 0,5 to 10 years old and 65% of the general population had anemia (Coimbra Jr, 1989; Santos, 1991).

In Rio de Janeiro and São Paulo, Serafim (1997) found 69% of anemia in Guaraní children from 0-65 months, reaching 82% for those ranging from 6-24 months. It is worth mentioning that for the Brazilian population, anemia is estimated to vary from 22% to 45%. (FUNASA –VIGISUS II Project, 2004)

> **Infectious Diseases:**

> **Malaria:** although seasonal and predominant in the Amazon region, it is still an important health problem for indigenous Brazilians and it was responsible for 5,6% of DIP cases in 2002. If we compare case occurrence for the last three years (2000 - 2002), there has been a remarkable case reduction from 26.941 to 12.393. However, prevalence has dropped in the last two years from 76,7 in 2000 to 35,1 cases per 1.000 inhabitants in 2002, that is an average annual fall of 27,1 %. (FUNASA, "Morbimortality Report 2002", 2003).

> **Respiratory diseases:** accounted for 29,8% of ambulatory care during 2002 and this is the second cause for demand of health services. Among Infections of the Upper Air Ways 90,5% corresponded to attention. Fatal pneumonia had a higher incidence in the age groups in the extremes of life in 2002; 81,5% corresponded to those under five years old while those under a year of age represented 48,2%. This demonstrates the great importance of this pathology in infant mortality among indigenous people. (FUNASA "Morbimortality Report 2002, 2003)

> **Tuberculosis:** 897 cases of all types of tuberculosis were notified in 2002 distributed in 33 (97,0%) Districts, 854 (95,2%) were pulmonary ones and 43 (4,8%) extra pulmonary. In the total cases, 42,8% were pulmonary forms confirmed by direct smears for bacilli in phlegm. Among the cases of pulmonary localization in those older than 15 years old (717) barely 344 (48,0%) were confirmed by direct smears for bacilli when at least 70% is expected not to be. This excess of types with no bacteriologic confirmation signals a low performance of direct smears for bacilli. The cases might be identified on the basis of radiological aspects without pursuing a confirmation on basis of etiology by finding the bacilli in phlegm. Tuberculosis is one of the main causes of disease among indigenous communities although diagnosis has not been bacteriologically confirmed in the diseases attributed to it. In 2002 it represented 1,3% of the total DEATHS due to all causes (FUNASA Morbimortality Report 2002", 2003)

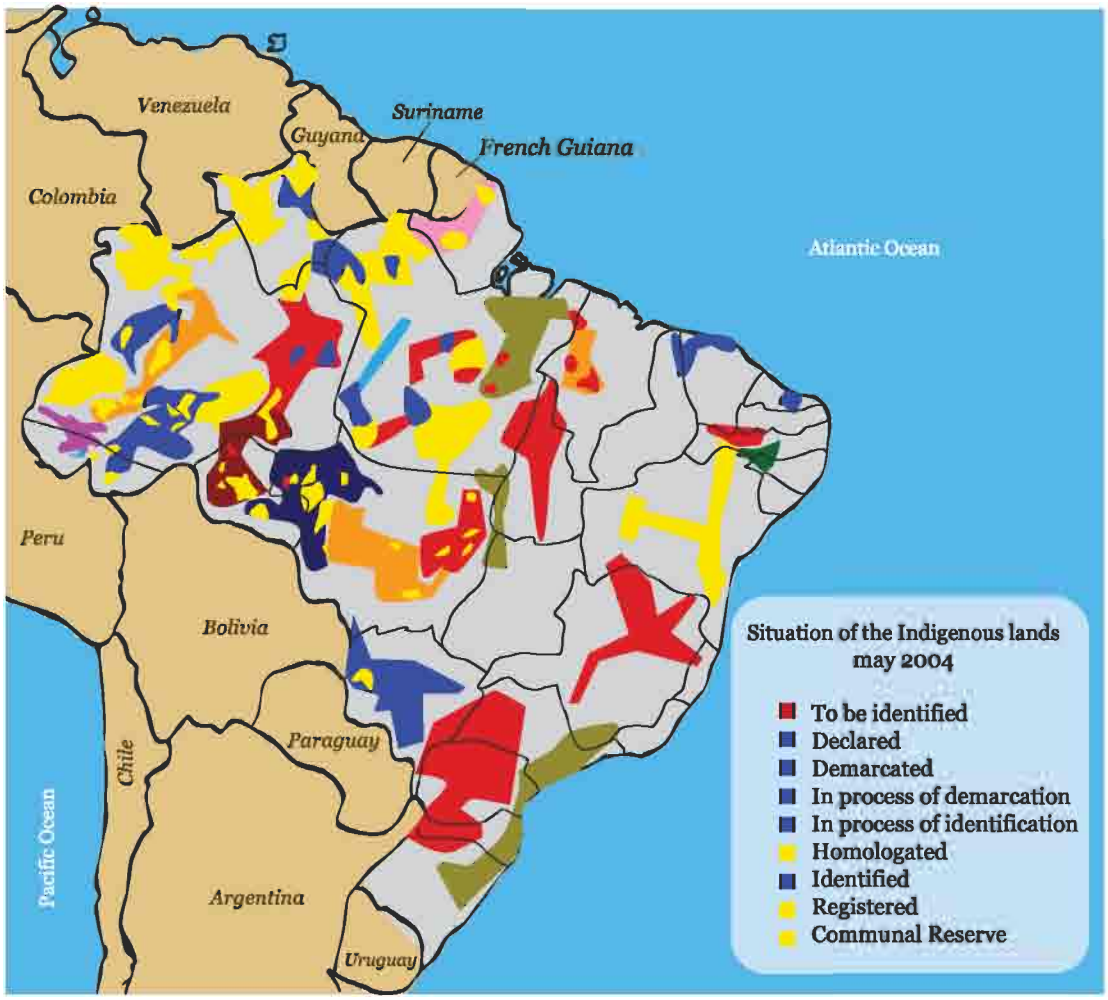
Table 2. Challenges, factors to be considered and inequities (part 5)

> **Diabetes, Obesity, Alcoholism:** The availability of epidemiologic data on prevalence of alcoholism in indigenous ethnia in Brazil is limited; some specific research made to some ethnias are barely known. A prevalence research made in the Terena of Mato Grosso do Sul in 1997 (Souza et al.) found a rate of 10,1% in the population in general, but when proportions are verified as per male gender, values of 31% were observed among the indigenous people living in villages and 22,4% among those not living in villages, with no statistical difference and statistically different when compared with the non indigenous population. Values were also similar to those of international bibliography and there is the confirmation that the age groups affected are those of minors even though more than 50% of probable dependant of male gender presented less than 30 years old as indicated by Shore et al. (1973); by Walker et al. (1994), which reinforced by El'Nell and Tereza (1996). (FUNASA – Project VIGISUSII, 2004)

There are no studies that encompass the occurrence of Diabetes in the whole Brazilian indigenous population. Among partial studies, "Vieira Filho (1977) related during the 70's the low frequency of DMII found among the Karipúna and Palikúr indigenous people to the genetic predisposition, feeding changes and obesity. Pava et al. (1999)... found reduced averages of glycemia in the Amondaca indias of Rondônia (55,1mg/dl).... (...) A study on cardiovascular health performed [among the indigenous groups Guarany-Mbyá that live in the coastal part of Rio de Janeiro]... identified prevalence ranging from medium to low of different cardiovascular risk factors as arterial hypertension, dyslipidemias and obesity (Cardoso, 2000; Cardoso et al., 2001). (CARDOSO, Andrey et al. in COIMBRA JR., Carlos (org.) – Epidemiology and health of indigenous people in Brazil. Rio de Janeiro: Ed. FIOCRUZ / ABRASCO, 2003, pp.169 y 171). In A study performed with 151 Guarani-Mbyá if Rio de Janeiro, Cardoso state that "they presented high prevalence of overweight, central obesity, hyperglicéridemia, HDL low cholesterol mainly in women. They are in an intermediate situation among the population groups as compared with the expression of cardiovascular risk factors. It was found a tendency of accumulation of factors defined as part of SRI [syndrome of insulinical resistance], and that there is an increased risk for presence of SRI among individuals over 50 years old and obese" (CARDOSO, Andrey et al. in COIMBRA JR., Carlos (org.) – Epidemiology and health of indigenous population in Brazil. Rio de Janeiro: Ed. FIOCRUZ / ABRASCO, 2003, p.182).

> **Suicide:** The incidence of suicide in the Brazilian indigenous population in 2002 was of 25,93/100.000 inhabitants. From the 99 deceased notified for this cause in 2002 (4,47% of a total of 2.211 notified deceased), 56 (56,6%) were registered in the Dsei Mato Grosso do Sul and 22 (22,2%) in the Dsei Alto Solimões. In other words, the 78,8% of suicides occurred in these two districts. Suicide mainly occurs in the 10 to 40 years old age group and the highest peak is in the range of 15 to 19, this is, adolescents. (FUNASA, " Report on Morbimortality 2002", 2003).

Indigenous peoples of **Brasil**



> DSEI No.: 34
> Total population: 426.920
> Indigenous lands: 662
> Ethnic groups: 210
> Languages: 170
> Villages: 3.487
> Municipality: 367

Source: FUNASA, 2004. ELETROBRAS, 2004. 20/10/2004.

Canada

1. International agreements and national policies

International Agreements	Legal Frameworks		Technical Units Responsible for the Health of the Indigenous Peoples	
	Constitution/ Policies National	Health Policies	Agencies governmental/ Ministry	Information contact
> Membership in multilateral institutions (e.g. UN, OAS, PAHO, Arctic Council) > Memorandum of Understanding with the United States > Letter of Intent between Canada and Mexico on Health Sector Collaboration	Health responsibilities are of provincial responsibility with the federal government retaining residual powers. **Key legislation:** > Constitution Act (1867) > Constitution Act (1982) > Canada Health Act (1985) http:// laws.justice.gc.ca/en/C-6/text.html > Indian Act (1985) http:// laws.justice.gc.ca/en/i-5/text.html > Department of Health Act (1996) http:// laws.justice.gc.ca/en/h-3.2/text.html	FNIHB's mandate is based in policy > Indian Health Policy (1979) http://www.hc-sc.gc.ca/fnihb-gspni/fnihb/bpm/hfa/transfer_publications/indian_health_policy.htm	> Health Canada (First Nations and Inuit Health Branch) >CIHR (Canadian Institute on Health Research) >Indian and Northern Affairs Canada (eg. water & sewage) >Provinces and Territories	> Mohan Denetto, Senior Advisor FNIHB (613) 957-3440 E-mail: mohan_denetto@hc-sc.gc.ca

2. Strategic Partnerships and networks of interinstitutional and intersectoral collaboration (part 1)

Agreements	> Memorandum of Understanding between Health Canada of the Government of Canada and the Department of Health and Human Services of the Government of the United States of America, 2002 > Cooperation Agreement between Canadian Institutes of Health Research (CIHR), the National Health and Medical Research Council Australia (NHMRC) and the Health Research Council of New Zealand (HRC), 2002 > Letter of Intent between CIHR and US National Institutes on Health, 2004
National projects, interinstitutional/ interesectorial	**EXAMPLE:** A tri-partite approach to developing a new model of primary care for Eskasoni First Nation: This project will pilot a collaborative approach by testing the effectiveness of a tri-partite steering committee composed of representatives from MSB, the Nova Scotia government and the Eskasoni Band. This approach is expected to improve shared accountability and foster efficient and effective use of health care resources. The mandate of the steering committee will be to lead the piloting and evaluation of a team approach to providing primary care services to the residents of Eskasoni. The team would include two physicians, a nurse clinician, a health educator, a counsellor and possibly a clinical pharmacist, among others.
Projects multicountry	**EXAMPLE:** In 2002, the Canadian Institutes of Health Research (CIHR), the National Health and Medical Research Council of Australia (NHMRC) and the Health Research Council of New Zealand (HRC) agreed to undertake a trilateral partnership collaboration to support research in the area of Indigenous peoples health with the goal of improving the health of Indigenous peoples in these three countries. Through this innovative agreement, Canada, Australia and New Zealand will use existing knowledge and new research to address the disparities between the health of Indigenous peoples and the health of the general population.
Interinstitutional/ intersectoral forums	See the Aboriginal Canada Portal, available at: http://www.aboriginalcanada.gc.ca/acp/site.nsf/en-frames/index.html
Indigenous organizations that include health in its political agendas.	Assembly of First Nations, Inuit Tapiriit Kanatami, Métis National Council, National Aboriginal Health Organization
Networks	**ACADRE EXAMPLE:** The flagship initiative at the Institute of Aboriginal Peoples Health (IAPH) of the Canadian Institutes of Health Research (CIHR) is the establishment of eight Aboriginal Capacity and Developmental Research Environments (ACADRE) at academic institutions across Canada. Together, these ACADRE centres represent a network of supportive research environments that facilitate the development of Aboriginal capacity in health research. The eight ACADRE centres are as follows:

2. Strategic Partnerships and networks of interinstitutional and intersectoral collaboration (part 2)

Networks	**1)** Atlantic **Aboriginal Health Research** Program - Dalhousie University 2) Institute for **Aboriginal Health - University** of British Columbia 3) **Indigenous Peoples Health Research** Centre - University of Regina, University of Saskatchewan, **First Nations University of Canada** 4) **Centre** for Aboriginal Health **Research** - University of Manitoba 5) **Anisnawbe** Kekendazone Centre - University of Ottawa 6) **The Alberta ACADRE Network - University** of Alberta 7) Indigenous Health Research Development Program - University of Toronto, McMaster University 8) **Nasivvik Centre - Université Laval** **In total, there are 92 ongoing First Nations** and Inuit health research projects that are funded **by CIHR-IAPH, the Social Sciences** and Humanities **Research Council (SSHRC),** or **the Canadian Population Health Initiative** (CPHI).

3. Primary health care and cultural diversity (part 1)

Policies that promote the incorporation of the perspectives, medicines, and Indigenous therapies in the National Health Programs.

EXAMPLES:

1) Canadian Pre-Natal Nutrition Program (CPNP) http://www.hc-sc.gc.ca/dca-dea/programs-mes/cpnp_main_e.html

> CPNP supports numerous projects in isolated, rural and urban areas. Almost a quarter of the program's clients are Indigenous women; and in some areas of the country they represent up to 80% of the clients. In many of these projects, Indigenous women govern, manage and deliver programs and services. They are active in decision making, role-modeling, peer-teaching, advisory committees and translation.

> CPNP funds community groups to develop or enhance programs for vulnerable pregnant women. Through a community development approach, the CPNP aims to reduce the incidence of unhealthy birth weights, improve the health of both infant and mother and encourage breastfeeding.

> CPNP enhances access to services and strengthens inter-sectoral collaboration to support the needs of pregnant women facing conditions of risk. As a comprehensive program, the services provided include food supplementation, nutrition counselling, support, education, referral and counselling on health and lifestyle issues.

2) ***Aboriginal Women's Health and Healing Research Group*** is a national network of First Nations, Métis and Inuit women researchers with the mission to create a supportive national context for Aboriginal women researchers and their communities.

3) ***Midwifery/Aboriginal women: prenatal care and postpartum care in their community "returning safe birthing to the community":*** The existing policy of evacuation of women in remote and isolated communities in late pregnancy for medically safe births can be perceived as being removed from the cultural, personal, family and community context. As a first step, nurses who work on reserve are implementing community-based strategies to improve first trimester recruitment to pre-natal care and to introduce the concept of birthing plans. Birthing plans involve opening dialogues with receiving hospitals and advocating for culturally safe practices. With these first steps, we expect to reduce overall risk while laying the groundwork for more community-based birthing in the future. Midwives and Aboriginal women are leading the drive to develop holistic services for women, babies and families that are built upon traditional practices, and promote community-based child bearing services. By reclaiming control over birth, communities can begin the process of restoring balance and harmony among their people, while at the same time ensuring health and safety for Indigenous mothers and babies and improving community wellness.

Experiences of harmonization of the Indigenous and conventional health systems

EXAMPLE: Health Integration Initiative

Funded from fiscal years 2003/2004 to 2005/2006, the purpose of the Health Integration Initiative (HII) is to explore, develop, and analyze models for better integration between federally and provincially/territorially funded health services to First Nations and Inuit (including services delivered by FN/I communities). The intent is to improve accessibility and quality of these services (including cultural appropriateness); make best use of existing capacity; create economies of scale; respond to community priorities; and develop solutions that benefit all partners. The HII is funding work in three areas of activity:

3. Primary health care and cultural diversity (part 2)

Experiences of harmonization of the Indigenous and conventional health systems	> Integration projects – to identify potential mechanisms/models for collaboration & harmonization between First Nations/Inuit and Provincial/Territorial health systems and stimulate momentum. > Research and analysis – to improve knowledge about integration and to encourage discussions between all stakeholders (governments, FN/I organizations, experts, etc.) on this issue. > Development of a policy framework for Health Canada's First Nations and Inuit Health Branch – to identify options for the implementation of a step by step approach to integration. As an example of harmonization of conventional and Indigenous health systems, one HII demonstration project (North Peace Tribal Council, Alberta) includes the establishment of an advisory committee of elders to identify culturally appropriate approaches to diabetic foot care that will improve participation and compliance.
Traditional healers' associations	
Training and human resources development programs (research and fellowships)	**EXAMPLES:** **1)** *Health Careers Program:* The Indian and Inuit Health Careers Program (IIHCP) created in 1984 in response to the evident disproportionately low numbers of Aboriginal health professionals aims at increasing awareness of health careers opportunities and fostering an interest in health science studies to Aboriginal students. The overall goal of the program is to increase the number of Aboriginal health professionals. The Program supports community-based and regional activities which typically include career fairs, health professional role models, school visits, career-related summer employment and science camps. Some Regions also support Post Secondary institutions to provide culturally relevant programs and other supportive programs for Aboriginal students in health sciences to ensure their success in their studies. The IIHC Programs also funds a Health Careers Bursaries and Scholarships Program, managed by the National Aboriginal Achievement Foundation. Eligible applicants are Aboriginal students studying in post secondary health science studies leading to a career in health. **2)***Asset Mapping:* The Fetal Alcohol Spectrum Disorder (FASD) Strategic Programming unit in the First Nations and Inuit Health Branch (FNIHB) is using a new community development tool that has been very successful at the community level. Asset mapping offers a different approach to addressing Fetal Alcohol Spectrum Disorder (FASD). It represents a shift from looking at deficits - a community's weaknesses - to focusing on its strengths.

Training and human resources development programs (research and fellowships)

A trained First Nations or Inuit facilitator gets people from his or her community together for a meeting about FASD; including band council members, community health nurses, tribal elders, early childhood education teachers and parents. The facilitator leads them in developing a community asset map. Instead of asking, What are we missing and how can we get it, the sessions concentrate more on, What do we have already and What can we do right now?

Asset mapping places a much more positive spin on addressing health issues and this approach can foster improved networking and idea-sharing in the community. Aboriginal communities are enjoying this approach because it is easy to use, accessible and requires very little financial resources.

The FASD unit piloted the first train-the-facilitator course in asset mapping in December 2003 in Winnipeg, Manitoba. Since then, it has been training community facilitators in southern regions and is currently developing a plan for training in the North.

4. . Information, analysis, monitoring, and management

Information on the demographic, socioeconomic and epidemiological profile of the Indigenous peoples	Refer to hard copy of included with this Evaluation Instrument "A Statistical Profile on the Health of First Nations in Canada" Health Canada, 2003. This publication is also available online at the following address: http://www.hc-sc.gc.ca/fnihb/sppa/hia/
Information systems, monitoring, and evaluation of the health of the Indigenous peoples includes the variable of ethnic group.	Aboriginal Health Reporting Framework (AHRF): currently under development: Health Ministers were directed to develop a framework of jointly agreed upon comparable indicators of health status, health outcomes and quality of service. Each jurisdiction will report on new indicators related to primary health care, healthy human resources and catastrophic drug coverage as well as the previous indicators. Health Canada will report on 18 core indicators. FNIHB has information on ten of these. First Ministers have directed Health Ministers to consult with Aboriginal peoples on the development of a comparable Aboriginal Health Reporting Framework. They further agree to consult with Aboriginal peoples in this effort, to use comparable indicators, and to develop the necessary data infrastructure. This reporting will inform Canadians on progress achieved and key outcomes. It will also inform Canadians on current programs and expenditures, providing a baseline against which new investments can be tracked, as well as on service levels and outcomes.
Maps of location of the Indigenous peoples in the countries in accordance with the political division of the country (include the map in the Annex)	Inuit: http://geodepot.statcan.ca/Diss/Maps/ThematicMaps/aboriginal/National/Cda_Aborig_Inuit_Ec_f1.pdf Métis: http://geodepot.statcan.ca/Diss/Maps/ThematicMaps/aboriginal/National/Cda_Aborig_Metis_Ec_f1.pdf North American Indian: http://geodepot.statcan.ca/Diss/Maps/ThematicMaps/aboriginal/National/Cda_Aborig_NAI_Ec_f1.pdf Total Aboriginal: http://geodepot.statcan.ca/Diss/Maps/ThematicMaps/aboriginal/National/Cda_Aborig_TABP_Ec_f1.pdf > See annex map *(pages. 97 - 100)*
Characterization of Indigenous peoples with regard to health and living conditions, social organization and systems of beliefs and values that influence the maintenance and restoration of health.	The opinions expressed in these publications are those of the authors and do not necessarily reflect the views of the Government of Canada or Health Canada. For a comparison of health status among First Nations peoples and information about protective and resilience factors refer to attached: Chandler, M. J. & Lalonde, C. (1998). Cultural continuity as a hedge against suicide in Canada's First Nations. Transcultural Psychiatry, 35, 191-219 For an overview of current developments refer to attached: "Who's doing what" An Environmental Scan of select Provincial, National, and International Health-related Organizations/Initiatives that may influence Aboriginal Health Policy. Discussion Paper prepared for the National Aboriginal Health Organization Last Revised April 1, 2002

Periodic publications on the health of the Indigenous peoples	**1)** Native Studies Review - published by the University of Saskatchewan **2)** Journal of Aboriginal Health - published by the National Aboriginal Health Organization (NAHO) **3)** International Journal of Circumpolar Health - published by an international consortium with Canadian representation **4)** Pimatisiwin: A Journal of Aboriginal and Indigenous Community Health - published by the Alberta ACADRE Network **5)** Health Policy Research Bulletin http://www.hc-sc.gc.ca/iacb-dgiac/arad-draa/english/rmdd/bulletin/bulletin5.pdf (specific issue which pertains to Aboriginal Health)
Section on health of the Indigenous peoples on the Web page of the Ministries of Health, PAHO, or other institutions (electronic address)	**1)** FNIHB website: http://www.hc-sc.gc.ca/fnihb **2)** NAHO website: http://www.naho.ca **3)** CIHR Institute of Aboriginal Peoples' Health website: http://www.cihr-irsc.gc.ca/e/8668.html

Second part

1. **Which are the most relevant achievements in the health care of the Indigenous peoples in the period 1995-2004?**

2. **Which are the priority problems in the health care of the Indigenous peoples of the country in the area national and subnational?**

3. **Which are the aspects to consider in the insertion of the health of the Indigenous peoples as priority in the processes that the country is promoting in the renewal of the Strategy of Primary Care and in the achievement of the Millennium Goals?**

Strategic Analysis

Strengths: characteristics specific of the country that would facilitate the actions aimed at the improvement of the health of the Indigenous peoples.	**Weaknesses:** negative aspects within the country that would hinder the actions aimed at the improvement of the health of the Indigenous peoples
Canada is a leader in the field of health. Our universal health care system is a model, especially our strong primary care system, which is based on the 5 Canada Health Act principles of: >Public Administration >Comprehensiveness >Universality >Portability >Accessibility Healthcare is a federal government priority. Furthermore, a commitment was made in the 2002 Speech from the throne to "close the gap in life chances between Aboriginal and non-Aboriginal Canadians". For FNIHB, this commitment is translated into a total budget of $1,677 million.	The main challenge that Canada faces is the issue of inter-jurisdictional coordination. It is a multi-actor process and issues of coordination across jurisdictions may become a complicating factor which impedes implementation of certain initiatives. A key issue faced by FN/I is difficult/costly access to health care due to geographical isolation. We thus possess a strong universal system yet in order to guarantee its sustainability we must address the key challenges posed by the issues of coordination across jurisdiction and access for all.
Opportunities: : factors that are in the context, and that it is thought that will act in favor of the actions aimed at the improvement of the health of the Indigenous peoples.	**Threats:** negative factors that can affect the implementation of actions aimed at the improvement of the health of the Indigenous peoples.
September 13, 2004 - First Ministers and Aboriginal Leaders agreed on the need for an action plan to improve health services for all Aboriginal peoples and committed to: >an Aboriginal Health Transition Fund to enable governments and Aboriginal communities to devise new ways to integrate and adapt existing health services to better meet the needs of all Aboriginal peoples; >an Aboriginal Health Human Resources Initiative to increase the number of Aboriginal people choosing health care professions; adapt current health professional curricula to provide a more culturally sensitive focus; and to improve the retention of health workers serving all Aboriginal peoples;	Delivery of health services to Aboriginal people is managed through a complex patchwork of jurisdictional arrangements that makes it challenging to address gaps in quality and accessibility of services. There remain a number of unresolved issues within the intergovernmental environment that need attention in order to close the health status and access-to-services gap between services for Aboriginal and non-Aboriginal Canadians, and to improve integration, including: >jurisdictional disagreements regarding roles and responsibilities for First Nations, Inuit, Métis and non Status Indians; and

Strategic Analysis	
> programs of health promotion and disease prevention, focussing on suicide prevention, diabetes, maternal and child health, and early childhood development > They also committed to the development of a Blueprint to improve the health status of Aboriginal peoples and health services in Canada, which would: > improve delivery of and access to health services to meet the needs of all Aboriginal peoples through better integration and adaptation of all health systems; > include measures that will ensure that Aboriginal peoples benefit fully from improvements to Canadian health systems; and > include a forward looking agenda of prevention, health promotion and other upstream investments for Aboriginal peoples.	> differences between federal/provincial/territorial health services that make integration more difficult. With the many political actors involved in Aboriginal health, arriving at viable solutions can be complex and time-consuming.

Third part

Table 1. Population and Indigenous peoples of the Canada (population expressed in thousands of inhabitants)

Population National	Population Indigenous	%	Peoples
31,414	976*	3.11	3**

*Aboriginal Identity (i.e. First Nations, Inuit and Metis)
** Constitutionally recognized groups

Table 2. Challenges, factors to consider, and inequities [6] (part 1)

Challenges

Strategies of health and public health should include and address the structural factors, of risk and to be inserted in the strengths of the Indigenous peoples:

Factors to consider

- **Location:** A community's degree of isolation may affect the resources it receives for public and community health services. 57% of First Nations and 73% of Inuit live in rural, remote or Northern communities. A major problem for people in rural, remote and northern communities is the distance they have to travel to reach medical services. Aboriginal people have less access to health care services than the general population because their communities tend to be small and located in remote areas. For 2/3 of the population in rural/remote communities, physicians are more than 100 km away.
- 64.2% of First Nation communities are non-isolated communities as they are accessible by road and are less than 90 kilometres from physician services. 14.4% are semi-isolated communities which means that the community has road access, but the nearest physician services are farther than 90 kilometres away. 17.9% of communities are considered isolated. They have scheduled flights and good telephone service but no road access. Remote isolated communities have no scheduled flights or road access and minimal telephone and radio service. There are 3.5% of First Nation communities that are considered remote isolated. (Health Canada, 2002)
- Registered Indians On-reserve: 445,428-
- Registered Indians Off-reserve: 285,158-
- Number of First Nation communities: 626 (Indian and Northern Affairs, 2003)
- First Nation communities of 1,000 or less: 90% (Indian and Northern Affairs 2001 - 2002)
- Population under 20 yrs.: 45% (Statistics Canada, Census 2001)
  Inuit Population: 45,075

Ethnic heterogeneity and cultural: No available information.

Culturally appropriate care: Key issues include the means by which the provinces/territories and the federal government could integrate traditional healing into conventional healthcare. The issue of cultural diversity and multiple languages within Aboriginal communities must be recognized in the construction of programs and the delivery of services.

Inequities

- **Life Expectancy (years):**

	First Nations	Canada	Gap
Males	**68.9**	**76.3**	**7.4**
Females	**76.6**	**81.8**	**5.2**

Note the following definitions:

[6] Aboriginal: This refers to that population of indigenous peoples in North America such as Metis or Inuit or those that have official Indian Status (defined by the Indian Act) or have membership in a band or First Nations.

[2] Registered Indians: Refers to those that are registered under the Indian Act.

Table 2. Challenges, factors to consider, and inequities (part 2)

Since 1980, life expectancy for First Nation males and females has increased 12.6% and 13.1% respectively.

> **Poverty (low income in 2000):**
> Aboriginal Peoples - 34%
> Non-Aboriginal Canadians - 16%
> (Canadian Population Health Initiative: Improving the Health of Canadians. 2004)
> From 1990 to 1995, average individual income among all Registered Indians rose from $11,941 to $14,833. (Indian and Northern Affairs 2000)

> **Illiteracy :**
(no data available)

> **Employment rates:**
Registered Indians on-reserve - 37%
Canadians - 62%
In 2001, Registered Indians, 25 - 44 year-olds had the highest employment rate at 54.7%.
(Statistics Canada, 2001 Census)

> **Unemployment:**
Aboriginal Peoples - 19%
Non-Aboriginal Canadians - 7%
(Canadian Population Health Initiative: Improving the Health of Canadians. 2004)

> **Basic services**

> **Water:** In 1999-00, 41.4% of the First Nations communities (south of 60 degrees latitude) reported that at least 90% of homes were connected to centralized water treatment plants. In 1999, 65 First Nations and Inuit communities were under a boil water advisory for varying lengths of time - an average of 183 days of boil water advisories per infected community. In only 24% of the cases, was the water quality issue resolved in less than a week, resulting in the removal of the boil water advisory.

> **Housing:** Shelter is a significant issue among First Nations communities, as only 56.9% of homes were considered adequate in 1999-00. Overcrowding is a concern with 19% of the dwellings on reserves having more than one person per room, compared with 2% of dwellings for Canada as a whole. Overcrowded housing is associated with an increased risk of tuberculosis in a community. As average number of persons per room increases, so does the rate of tuberculosis. The tuberculosis rate in First Nations was 8 to 10 times higher than that of the entire Canadian population in 1999.

> **Infant mortality :** *(Health Canada, 2003)*
First Nations infant mortality rate in 2000 was 6.4 per 1,000 live births. This compares to the 1979 First Nations rate which was 27.6 per 1,000 live births. The infant mortality rate for Inuit in Nunavik, at 25.5 deaths per 1,000 live births (2003), surpasses that of the First Nations.

> **Maternal mortality:** No reporting.

> **Malnutrition:** No indicator.

> **Infectious Diseases :** *(Health Canada, 2000)*
First Nations had elevated rates of pertussis (2.2 times higher), rubella (7 times higher) and shigellosis (2.1 times higher) for the year 2000 compared to the general population. The notification rate of genital chlamydia was almost seven times higher than the national rate, while the reported hepatitis C rate -- based on case reports of chronic and acute hepatitis C -- was one-third lower than the national rate. Giardiasis was just over half the national rate.

> **Chronic Diseases:**
First Nations on-reserve compared to the rest of Canada:
> Arthritis or rheumatism - 36% higher
> High blood pressure - 31% higher
> Asthma - 30% higher
> Diabetes - 3.7 time higher
> (Statistics Canada, Aboriginal Peoples Survey, CCHS)

Table 2. Challenges, factors to consider, and inequities (part 3)

> **Tuberculosis:** The tuberculosis rate in First Nations was 8 to 10 times higher than that of the entire Canadian population in 1999. Overcrowded housing is associated with an increased risk of tuberculosis in a community. (Health Canada, 2003)

> **Diabetes:** With respect to self-reporting of illness, the 1997 First Nations and Inuit Regional Health Survey reported an overall diabetes prevalence of 11% among the First Nations and Inuit. Overall, the age-standardized prevalence of diabetes among First Nations people is three to five times that of the general population. The diabetes epidemic has been slower to impact the Inuit population compared to First Nations. In 1997, the First Nations and Inuit Regional Health Survey reported a diabetes rate of 4.0% in the Labrador Inuit, which was higher than the comparable Canadian rate.
(Health Canada, 2003)

> 7% of the Aboriginal non-reserve population reported diabetes, compared with 4.3% of the total Canadian population.

> Diabetes among the non-reserve Aboriginal
> population 15 years of age and over
> North American Indian - 8.3%
> Metis - 6%
> Inuit 2.3%

> **Obesity :** 25% of Aboriginal people (off reserve) are obese. Aboriginal (off reserve) obesity rates are almost 2 times greater than Canadian rates.
(Canadian Population Health Initiative: Improving the Health of Canadians. 2004)

> **Alcoholism :** *(Health Canada, 2003)*
First Nations injury and poisoning mortality data in Saskatchewan from 1985 to 1987 showed that alcohol use was implicated in 92% of motor vehicle accidents, 46% of suicides in the 15-34 age group, 38% of homicides, 50% of fire and drowning deaths and 48% of deaths in the 'other' category.

In 1985-86, use of alcohol and drug treatment centres by Aboriginal people in Ontario was 6 times higher than what would have been predicted based on the number of Aboriginal persons in the province or based on equal per-capita use between Aboriginal and non-Aboriginal people.

The 1991 Aboriginal Peoples Survey reported that 73% of First Nations respondents said alcohol was a problem in their communities. More than half the respondents in the First Nations and Inuit Regional Health Survey reported no progress in reducing alcohol and drug abuse between 1995 and 1997.

> **Cancer:** *(Health Canada, 2003)*
In 1999, the Canadian mortality rate for Cancer (186.5 deaths per 100,000 population) was one-third higher than that of the First Nations rate of 141.5 deaths per 100,000 population. The mortality rate for lung cancer in First Nations is lower than the Canadian rates, at 60.6 per 100,000 population for males and 33.4 for females (compared to Canadian male and female rates of 70.3 and 34.8, respectively) - however, the estimated smoking rate of over 60% for First Nations is 3 times that for Canada.

> **HIV/AIDS :** *(Health Canada, 2002)*
The proportion of Canada's total AIDS cases contracted by Aboriginal people climbed from 1.0% in 1990 to 7.2% in 2001. The proportion of Aboriginal people with HIV who are under 30 years of age, female or injection drug users are all greater than the corresponding proportions among non-Aboriginal cases.
(Health Canada, 2003)

From 1998 to 2001, an estimated 605 Aboriginal people in Canada had positive human immunodeficiency virus (HIV) test reports, representing 25.9% of all reports in Canada with known ethnicity.

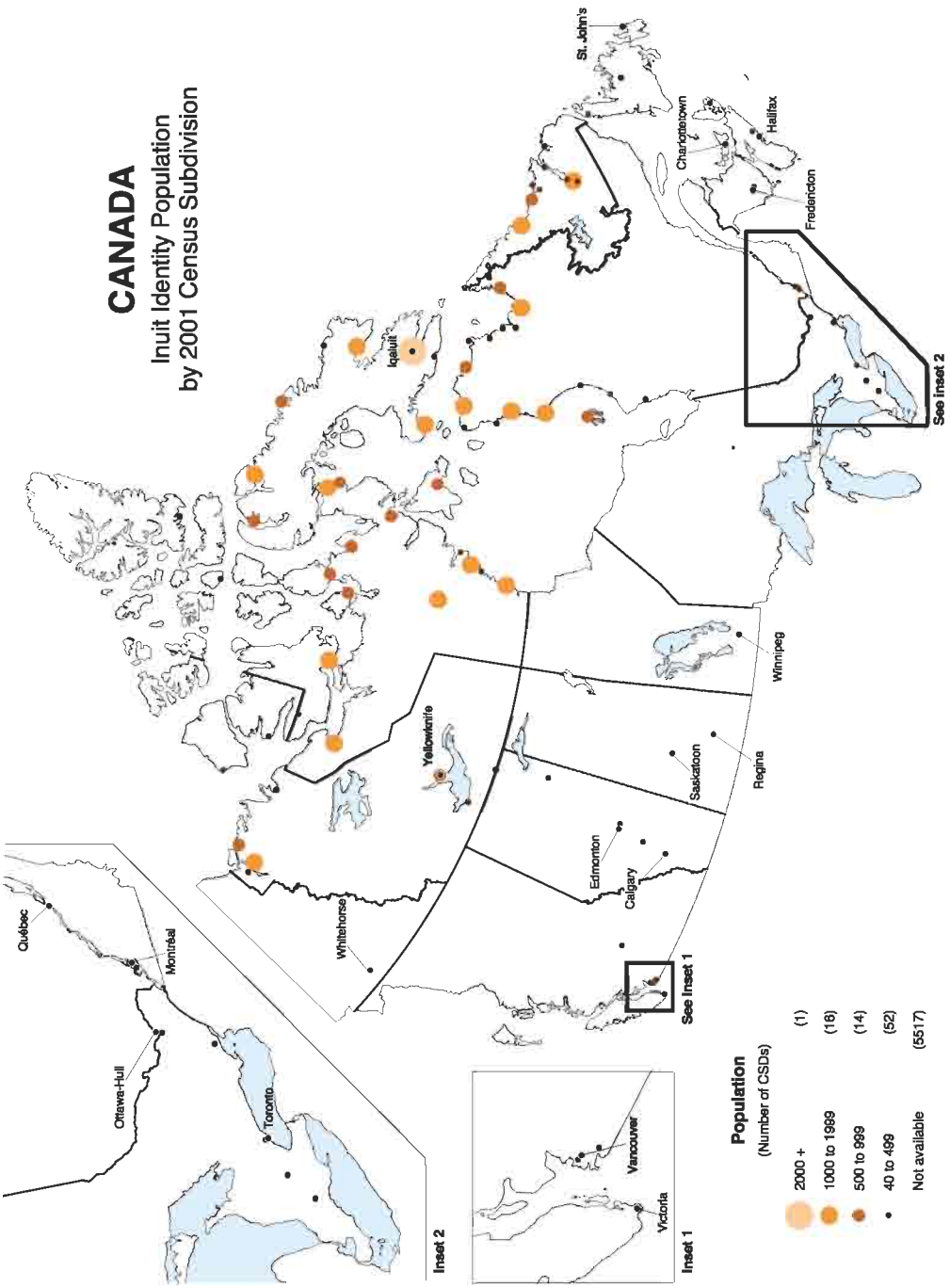
Table 2. Challenges, factors to consider, and inequities (part 4)

Suicide: *(Health Canada, 2003)*

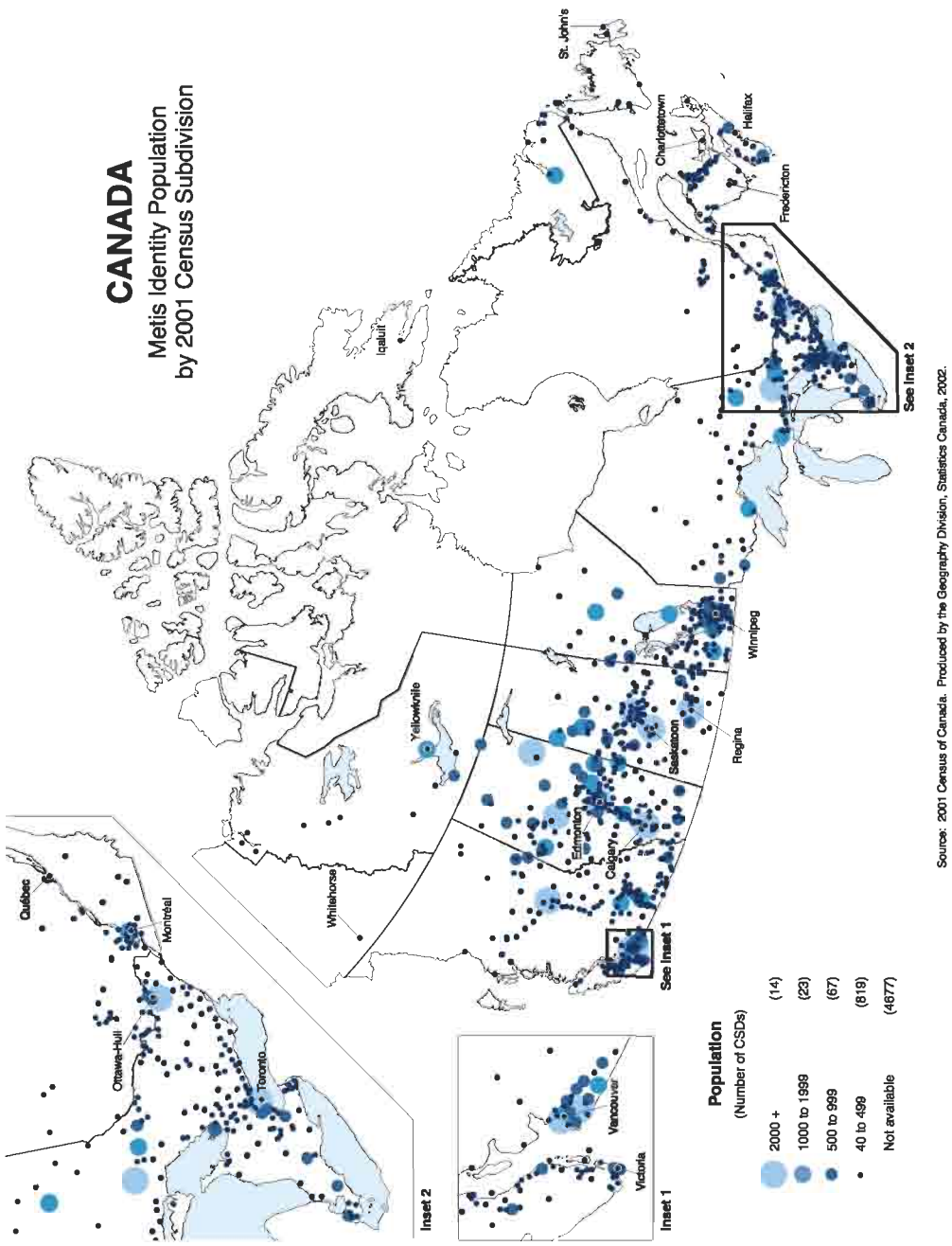
> The crude First Nations suicide rate for 1999 was 27.9 per 100,000, over twice the Canadian rate of 13.2. In 1999, suicide accounted for 38% of all deaths in First Nations youth and 23% of all deaths in First Nations early adults. Suicide has been identified as the number one health priority among Inuit – the overall suicide rate is 79 per 100,000 (the Nunavik rate is higher at 82 per 100,000).

For First Nations on reserve, in 2000, suicide accounted for 28% of all deaths in youth (10-19 years) and 28% of all deaths in early adulthood (20 - 44 years). The suicide rate was 24.1 deaths per 100,000 population.

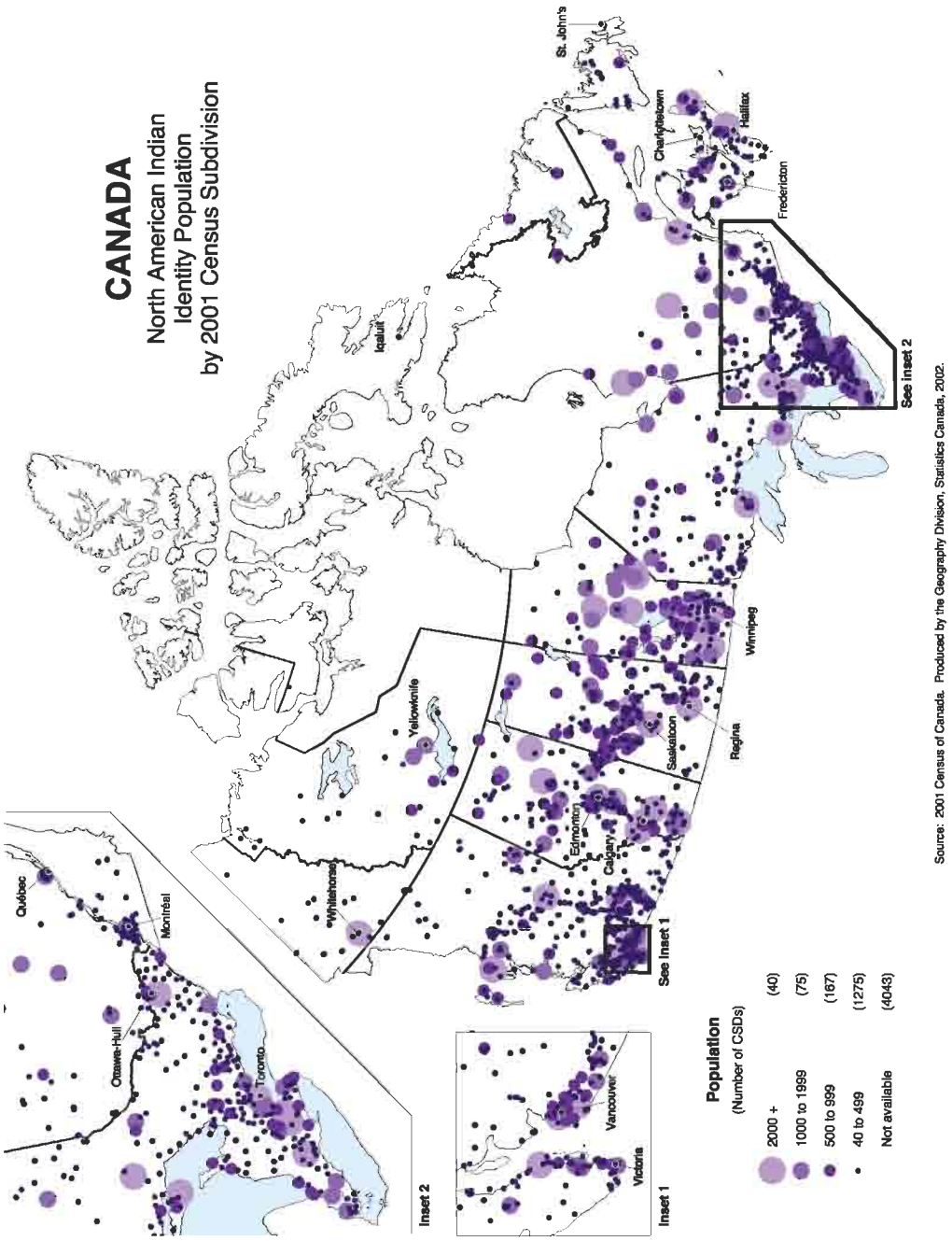
Map of Population and Indigenous Peoples of **Canada**



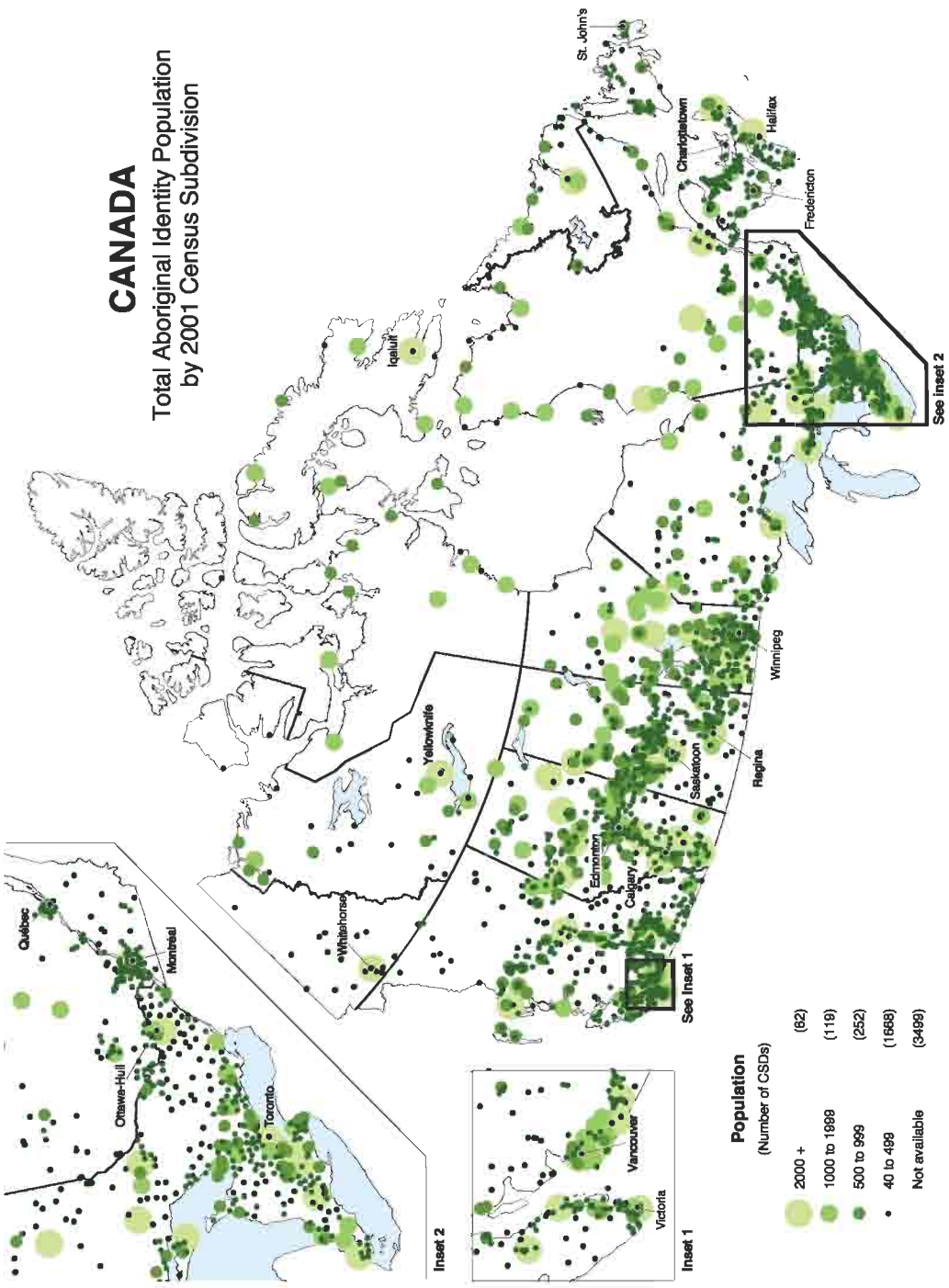
Map of Population and Indigenous Peoples of **Canada**



Map of Population and Indigenous Peoples of **Canada**



Map of Population and Indigenous Peoples of **Canada**



Chile

1. International agreements and national policies

International agreements	Legal Framework		Technical units accountable for the Health of Indigenous people	
	Constitution /National Policies	Health Policies	Government / Ministry instances	Contact Information
Resolution CD37.R5[1] Resolution CD40.R6[1] Agreement for Biological Diversity[2] art. 8 j) Convention against racism, discrimination, xenophobia and other forms of intolerance.	**Indigenous Law N° 19.253 D. of 5-10.1993[3]** Government Indigenous Policy . "Historical Truth and New Treatment", 2004.[4]	Health policy and Indigenous Peoples, 2003[5] Sanitary Authority Law N° 2763, 2004[6]	MIDEPLAN. Policy Coordination and Indigenous Programs .[7] National Corporation of Indigenous Development (CONADI) Health Unit and Indigenous Peoples. Rectory Division and Sanitary Regulation. Ministry of Health	> Lic. Margarita Sáez E-mail msaez@minsal.gov.cl Mideplan CONADI

[1] The 35 Member States of the PHO expressed their commitment to prioritize care to the indigenous peoples of the Americas by signing Resolution CD37.R5 (1993) and CD40.R6 (1997).
[2] "Agreement on Biological Diversity", ratified by Chile on September 9, 1994 and enacted as a Law of the Republic in 1995.
[3] "Indigenous Law N° 19.253" on "Indigenous Protection, Promotion and Development" October 1993 establishes recognition, respect and protection of the indigenous cultures and languages, will consider the use and conservation of indigenous languages, besides Spanish in areas of high indigenous density.
[4] Government Policy, as a result of the National Commission for Truth and Reconciliation, made official by President Ricardo Lagos by means of Supreme Decree N° 19 of January 18, 2001.
[5] "Policies on Health and Indigenous Peoples". Ministry of Health, National Health Fund, Health Program and Indigenous Peoples. Chile Government. January 2003.
[6] Incorporation of indigenous peoples as a priority group in the Public Health Plan. Continuity of the work on health and indigenous peoples in the new Subsecretariats of Health: Public Health and Assistance Network Management.
[7] Ministry of Planning and Cooperation. "Final Report Work Group for Indigenous Peoples.". Palacio La Moneda, May 2000.

2. Strategic Alliances and Interinstitutional and intersectorial cooperation networks

Agreements	Multiphase Program for the Integral Development of Indigenous Communities. Agreement N°1311/OC-CH Agreement N°1311/OC-CH.
National, interinstitutional / intersectorial Projects	Program for the Integral Development of Indigenous Communities. Origins Program. Health Component. CONAF/MINSAL agreement.
Multi country projects	Agreement for exploratory exchange with Ecuador. Internships between countries.
Interinstitutional/ intersectorial Forums	National group and Participatory Design of the Environmental Health Program in Indigenous Regions, participants: Ministry of Health, Ministry of Public Works and Ministry of National Planning through the Origins Program.
Indigenous Organizations that include health in their politic agendas.	Aymara National Council, Council of Atacameños Peoples. Indigenous work-groups of the Metropolitan Region, Indigenous Parliament Rapa Nui, Indigenous Regional Council of Magallanes, Buta Huillimapu Council Leaders, Picún Huillimapu Council.
Networks	Intercultural Health network of interinstitutional nature. Participants: professionals, academics, indigenous representatives, PAHO/WHO representatives in Chile and MINSAL (organization of events, sharing information).

3. Primary health care and interculturality

Policies that promote the incorporation of indigenous perspectives, medicines and therapies into the National Health Programs.	The objectives of Health and Indigenous Peoples[8] are: to contribute to the recognition, protection and development of the knowledge and traditional practices of indigenous peoples in health; and to make progress in the development of local experiences of collaboration between medical systems, especially at primary care level[9] Government policies stemmed from the National Commission for Truth and Reconciliation. In October 2004, a ministry group was created in order to recognize, protect and develop indigenous health systems[10] . In 2005, a working group was implemented with indigenous and technical participation in order to recognize indigenous medicine. Likewise, during the second part of 2004, a comparative study was started concerning the recognition of indigenous medicine, which provides a framework for the legal and regulatory proposals.
Experiences of harmonization of indigenous and conventional health systems.	Urban health centers where the machi are taken care of include: Centers of Complementary Health in Kompu and Comunda de Panguipulli, X region; Boroa Filulawen, Chol Chol Hospital and Makewe Hospital, IX region; Iquique hospital, I region; Ralco medical center, VIII region. The intercultural health component of the Origins Program is supporting local projects for the recovery and dissemination of indigenous medicine.
Associations of indigenous therapists	Associations of Machis and Iawentuen Puerto Saavedra; Healers Associations in Parinacota; Association of Medicine Women, Lanco
Programs for human resources training and development (research and scholarships)	Postgraduate in Health Intercultural Catholic University of Temuco; Training Program in service Origins Program and National Program; University of Antofagasta grants indigenous scholarships for Family Medicine, University of Concepción, course at Nursing School; University of the Frontier, Internship of Medicine students; Training program in Intercultural Bioethics of the University of Chile; University Arturo Prat de Iquique, Nursing School.

[8] "Policies on Health and Indigenous Peoples". Ministry of Health, National Health Fund, Health and Indigenous Peoples Program, Chile Government, January 2003
[9] Ministry of Health. "From Medical Office to Health Center", Santiago, Chile, March 1993.
[10] In the presence of the Ministry of Health, Dr. Pedro García and the Undersecretary of Health Dr. Antonio Infante, the first work meeting took place on October 6, 2004, with the Ministry's technical team that, parallel to the activities carried out by Health Services with the regional indigenous representatives of the communities, organizations and agents of indigenous medicine at local level throughout the country, will develop a proposal for recognition of indigenous medicine. These work groups are aimed at designing a proposal to move forward on the recognition of indigenous medicine in Chile, and the establishment of a national strategy of medium and long term, involving the participation of the indigenous world.

4. Information, analysis, monitoring and management

Information on the demographic, socioeconomic and epidemiologic profile of indigenous peoples.	Studies performed by Víctor Toledo[11], Félix Aliaga[12] , Malva Pedrero[13] , Ana María Oyarce[14], Jaime Ibacache[15], Margarita Sáez[16] National workshops on Epidemiology and Interculturality.[17]
Information, monitoring and evaluation systems of indigenous peoples' health including the ethnicity variable.	CASEN Survey and population CENSUS include indigenous self-identification variable.
Maps of indigenous peoples in countries, according to the political division of the country (include map in the annex)	See maps annex. (page. 115
Characterization of indigenous peoples regarding their life and health conditions, social organization, beliefs and values that influence the maintenance and recovery of their health.	Makewe (PHO) Case Study, Systematization of Origins Program[18] , Urban Mapuches Study, HIV/AIDS Study[19]
Periodic publications about the health of indigenous peoples	Social Communication. Bulletins.
Section on the health of indigenous peoples available on the web site of the Ministries of Health, Public Works or other institutions (web address).	http://www.minsal.cl; OPS/OMS en Chile (pwr-chi.bvsalud.org, http://www.mideplan.cl/Programa Origenes.cl)

[11] PHO, 1997. Health Situation of Indigenous Peoples of Chile. Epidemiologic Profile.
[12] Aliaga, Félix, 2002. Epidemiologic Profile of the Mapuche Population. IX Region. Unpublished document.
[13] Pedrero, Malva, 2001. Setting the Grounds for an Intercultural Health Care Model on Sexual and Reproductive Health among Aymara women in Northern Chile. Unpublished document.
[14] Oyarce, Ana María and Susana Schkolnik,1994. The Mapuche: A multidisciplinary research on reductions of indigenous peoples of Chile in Demographic Studies of Indigenous peoples. CELADE-CIDOB;FNUAP-ICI Santiago, Chile.
[15] Ibacache Jaime, Sara Mac Fall and José Quidel, 2002. Transgression Epidemiology. Unpublished document.
[16] Sáez, Margarita, 2003. Demands and Needs in the use of Health Services and Primary Care by the Mapuche population who resides in two communes of the Metropolitan Region. Master Thesis in Public Health, University of Chile.
[17] Ministry of Health, Health Program and Indigenous Peoples, Araucanía Sur's Health Service "Health and Indigenous Peoples National Workshop. Health, Culture and Territory: bases for an intercultural epidemiology", Likanray – Brotes de Luna Nueva, Región de la Araucanía, Chile, 1998.
[18] Minsal, 2004. Systematizing Experiences in Intercultural Health Synthesis Report. Origins Program. Work document.
[19] Minsal, 2004. Characterization study of risk factors and HIV/AIDS vulnerability in emerging vulnerable populations. Research in progress.

Second part

1. What are the most relevant achievements in health care for indigenous peoples during the 1995-2004 period?

The Ministry of Health is currently developing two programs with specific budgets:
The National Program on Health and Indigenous Peoples from 1996, active in 22 out of 28 countries. The Integral Development Program for Indigenous Communities (Origin Program), active since 2001, in charge of 5 regions with 9 Health Services.

- Regarding health equity, positive discrimination mechanisms have been created concerning access, quality and care opportunities including: 102 intercultural facilitators and cultural advisors (which allow for timely and appropriate care).
- Contributions have been made to the achievement of sanitary objectives by means of improving the structure of posts, rural health stations, medicine purchases, financing of examinations of higher complexity, service purchases for lab examinations, inner eye tests and assistance operations. Progress in the resolution of ophthalmology, Otolaryngology and odontology problems by the purchase of services and supplies for the indigenous population.
  Increases have been made to the provision and frequency of rural rounds in regions I, II, VIII, IX, X. Health campaigns have also been implemented in order to solve problems in specialty care and health controls- as a way to improve the resolution capacity in far away locations. In the ADI[20] Lleu Lleu and Alto Bio Bio, a Bio Bio plan is being implemented by FONASA and the Arauco Health Services for medical care of specialties for the pehuenches and lafquenches people.
- The creation and support to homes that provide accommodation for rural indigenous populations in order to access specialty care in urban centers. This is done through hiring personnel, buying supplies and technical supervision. Implementation and fitting out space for care has arisen from joint proposals between the health teams and indigenous communities.
- The development of training programs in indigenous cultures for officers who have more contact with indigenous populations as a service network. Within the framework of the Origins Program, 4.400 officers from health centers have been trained and given knowledge in cultural relevancy in regions I, VIII, IX and X. As a result, from this training, management proposals have stemmed from trained officers, involving the indigenous community.
- Project consulting and financing for indigenous communities and organizations, with the purpose of recovering and strengthening indigenous medicine, improve the access and achieve cultural relevancy concerning health care.
- Before July 2004, a total of 146 projects have been implemented for rescue, strengthening and development of indigenous medicine within the framework of the Origins Program. The projects developed are geared towards the validation and fortification of the role of specialists of indigenous medicine. To re-educate the "Kimun" (knowledge) and train in indigenous health at intra-community level it is necessary to engaged in an exchange of knowledge and experiences between communities, the recovery and strengthening of ecosystems, and analyze the legal recognition of indigenous medicine and its implications.

[20] ADI: Indigenous Development Area.

2. What are the high-priority problems related to health care for indigenous people at national and sub national levels?

> The geographic accessibility of indigenous communities to health care in rural regions in the aymara, atacameño, mapuche, yámana and Kawashkar populations is a considerable problem. In the southern and aymara populations, for example, the presence of TBC is a relevant health problem, which is being researched in a socio-cultural epidemiologic diagnosis project with the participation of the native populations themselves[21].

Low interest in health programs because of a lack of cultural relevance. Even when some instruments to improve health programs have been modified, Woman's health (pregnancy, delivery and puerperium), child's psychomotor development, alcohol problems, and nutrition remain problematic.

With regards to the Rapa Nui people, the priority is to improve the results of the Aedes Aegypti Control Program on Easter Island, by strengthening community participation and environmental regulations, improving intersectorial work, promoting active participation of local institutions and organizations, and applying an intercultural framework. The Ministry of Health is participating in the Inter-Ministry Committee of the Extreme and Special Zones (CIDEZE), concerning the situation in Easter Island. The feasibility of the proposals include: improving the resolution capacity of the Hanga Roa Hospital; creating a special fund to be used in the costs of aeromedical evacuations; establishing the procedures to be followed concerning the special fund and medical emergencies; and determining that the transferred patients from Easter Island shall be given care in a Hospital of the Metropolitan Region, nowadays emergencies are taken care of in Santiago, at the Central Post and after that they are referred to the V Region, since the Island administratively belongs to the Health Service Valparaíso/San Antonio.

From the sanitary point of view, the situation of indigenous communities needs to be addressed concerning the access to safe water for human consumption, under basic drainage conditions. Based on this background, the deterioration of the native population can be verified, both at a national level and in communities with high percentages of indigenous populations (since a high percentage does not have the minimum necessary conditions for drinkable water consumption, which results in higher exposure to the risk of contracting enteric illness, such as cholera, hepatitis, typhoid, paratyphoid, diarrhea, etc).

3. What factors should be considered for the insertion of indigenous peoples' health as a priority in the renovation of the Primary Care Strategy and the achievement of the Millennium Development Goals?

> The majority of the strategies and actions developed concerning health and indigenous peoples are at the Primary Care level. From there, a network for health services is built with indigenous communities.

[21] Another results of this Project is the crearon of a Methodological Guideline for Epidemiological research with an Intercultural approach.

The Integral and Family Care Model is a fundamental took for the Reformatory process. Local experiences are being developed linking Primary Care with a family approach to intercultural health. Ralco (mapuche pehuenche) and in San Pedro de Atacama (atacameños) are pioneering experiences and useful for their replicability.

Concerning the Millenium Development Goals, the greatest challenges are reducing inequities, as the regions with the highest concentration of indigenous population have the highest equity gaps. The goal of reducing maternal mortality is linked to the indigenous population as part of a preventive strategy of home childbirth cases within the Aymara population. For this purpose, specific childbirth strategies are being developed with cultural relevance at the hospital level (Iquique Hospital). Concerning the reduction of HIV/AIDS, a study is being carried out in order to characterize the risk and vulnerability factors in relation to indigenous peoples to bring about relevant and validated prevention strategies.

- With regards to the improvement of access to drinkable water and basic drainage of rural indigenous communities, a special program has been created to promote the participation and inter-sectoriality. Intra and inter sectorial coordinations have been established to set the grounds for this program, where collaborative strategies have been initiated with SUBDERE, MOP and Ministry of Housing and Urban Development. The Ministry has granted support to the project.
- Concerning urban indigenous population in the Metropolitan Region, for the year 2005 a baseline of the socio-demographic situation, access, service use and quality perception of health care will be prepared, based on the consolidation of existing studies performed at community level.

Another challenge has to do with the design, validation and incorporation of consultative mechanisms and information in investment processes that involve, directly or indirectly, native communities. The management of health centers in communities with high concentrations of indigenous population will create consultation mechanisms to allow for the incorporation of cultural relevance into the medical-architectural models of the health service network.

Strategic Analysis	
Strengths: particular characteristics of the country that would facilitate the actions aimed at improving health of indigenous peoples.	**Weaknesses:** negative aspects within the country that would make it difficult for actions aimed at improving health of indigenous peoples.
Support from authorities of the Ministry of Health, Regional Ministry Secretaries and Health Directors towards the introduction of an intercultural approach in health; Health personnel trained in inter-cultural techniques, having the tools to orient health actions with cultural relevance; Leaders and managers with a positive attitude towards the efforts involved in the construction of an intercultural health model; > Indigenous participation in the design and evaluation of work plans on intercultural health; > Organization of exchange activities of medical knowledge with worshippers of traditional medicine; > Worshippers of traditional medicine validated and recognized – at the meetings for indigenous medicine – for the indigenous community itself; > Provincial meetings and rounds of Intercultural Health working with systematic participation of indigenous social management; Existence of a wide network of health services with national coverage; 22 health services with Health and Indigenous Peoples Plan and with technical teams accountable for the Health and Indigenous Peoples Program.	> Health recording systems do not consider the ethnic relevance variable; > Communities' participation is still relatively low; > Individualistic attitudes of some leaders are still predominant over the common interests of indigenous groups and communities; Difficulty in public institutionality to respond in a timely manner about committed matters, especially due to the administrative complexity of health services; > Not enough hours of human resources devoted to the implementation of health programs and indigenous peoples. Work overload of local teams; Difficulty in managing concepts regarding intercultural health; Insufficient training for teams involved in project execution; > Poor social communication development concerning the actions derived from the programs; > Protected program that has not managed to crosscut enough the health system.
Opportunities: factors that are in the context and are thought to act in favor of the actions tending to health improvement for indigenous peoples.	**Threats:** negative factors that may affect the implementation of actions aimed at improving the health of indigenous peoples.
> Favorable political context, supported by legal framework: Indigenous Law and Reconciliation Policy. Health Reform. One of the Reform's objectives is the creation of policies that incorporate an intercultural approach in health programs in communities with high indigenous concentration.	> A non-existent framework of indigenous rights that clearly supports public policies addressed to the mapuche world;

Strategic Analysis	
Work from universities aiming to introduce the intercultural approach in the basic training curriculum and postgraduate professional and technical programs. > International treaties that promote the recognition of indigenous peoples and their particularity.	Government's political will has not gained either political support in the most demanded milestones of indigenous peoples. Ratifying WLO Agreement 169, or constitutional recognition of indigenous peoples. Both initiatives have not been approved yet by the Parliament; > The gap between what the State knows about its indigenous peoples and what the realities are: > Ideological manipulation of the subject. > Insecurity regarding sustained financing support. > Current programs belong to the Government, not the State, which does not guarantee their continuity. Poor coordination among the different sectors of the State. Health issues among native people continue to be a marginal topic for State institutions.

Third part

Table 1. Population and indigenous peoples of Chile (population in thousands of inhabitants)

National Population	Indigenous Population	%	Peoples
15.116	692	4,6	8

Source: INE. CENSUS, 2002.
Note: Eight communities were asked about ethnic ownership and the results are not comparable with the 1992 Census, which estimated an indigenous population of 998.385 under the self-identification criteria with three communities.

Table 2. Challenges, factors to be considered and inequities (parte 1)

> Challenges

Health and public health strategies should embrace the structural factors, and risks and become a strength of indigenous peoples:

- Holistic vision of individual, family, community and environment welfare;
- Cultural, linguistic, organization, negotiation and leadership skills;

Adherence to community principles of reciprocity, solidarity and respect, as well as ancestral knowledge.

> Factors to be considered

> **Localization:** Chile: The country's indigenous peoples are diverse. They are located in rural zones (some of difficult access), as well as in urban sectors. Provided regions I (aymara), IX y X (mapuche) are the ones having the greatest indigenous presence in traditional settlements, the Metropolitan region gathers 23,7 of the total indigenous population in the country.

> **Ethnic and cultural heterogeneity:** According to the last Census, the indigenous population is calculated at 692.192 people belonging to eight communities, which constitutes 4.6% of the total population. The indigenous population is present in the whole country. Laws recognize the following peoples: aymara, quechua, atacameño, colla, rapa nui, mapuche, yagán and kawshkar. The diaguitas are not included, but their recognition is under study. Nowadays, six native languages are spoken in different condition: aymara, quechua, mapuche (mapudungun), kawashkar and rapa nui.

> **Culturally appropriate attention:** Participation and cultural relevance as an axis for the design, execution and evaluation of public policies on health and indigenous peoples. In the Regulations of Sanitary Authority, it is stated that the Ministry of Health is responsible for formulating policies that allow for the incorporation of an intercultural health approach in health programs of the communes with high concentration of indigenous population, allowing and favoring collaboration and complementarity between health care provided by the System and the one provided by indigenous medicine, which allows these people to get an integral and timely resolution for their health needs within their health context.

> Inequities

> **Poverty:** The regions with highest shortage (measured through basic needs) coincide with communities that have large indigenous populations (PHO, 1997). Poverty is higher among indigenous peoples than non-indigenous population. Poverty levels among indigenous peoples exceed 12 percent points, 32.2% compared to 20.1% of the non indigenous population. As for extreme poverty, it is more than double for the non-indigenous population, a situation that still exists in the rural environments, especially in the Araucania Region (CASEN 2000).

> **Illiteracy:** Illiteracy rates among the indigenous population are 8.4% and more than double the illiteracy rates in non-indigenous populations, 3.8% (CASEN 2000).[22]

> **Unemployment:** : There are higher unemployment rate among indigenous population, 13.3% compared to 10.2% for the non-indigenous population (CASEN 2000).

> **Utilities:** 86% of the population have access to drinking water, however, in rural communities with a high percentage of indigenous peoples, only 5.25% of Atacameños, 18.4% of Aymaras, and 17.9% of mapuches have access to these utilities. In the same communities, 70% of the population has sewer system, however only 6.6% of mapuches, 8.7% of Aymaras and 9.9% of Atacameños have access to this service (PHO, 1997).
According to the CASEN 2000 Survey, the drainage indicator among the indigenous population is 53.9% compared to 77.4 among the non-indigenous population.

[22] CASEN 2000 Survey results. Ethnics and poverty in Chile. www.mideplan.cl

Table 2. Challenges, factors to be considered and inequities (part 2)

> **Children Mortality:** : Child mortality is higher in indigenous areas in relation to the national average. In 1981, twenty two out of every thousand mapuche children born died before their first birthday, as compared to 19 non-mapuche children who died at that age[23] . This study coincides with another in areas of high indigenous concentration which shows that children mortality between 1992 and 1998 was 15 for the country and 40 out of 1000 NV in Aymará, 57 out of 1000 NV in Atacameños, and 43 out of 1000 NV in mapuche (PHO, 1997).

> **Mother mortality:** There is no epidemiologic data on indigenous populations.

> **Infectious diseases:** death caused by bronchopneumonia among indigenous children below 5 years old is proportionally higher as compared to non-indigenous children[24] . TBS is considerably higher in zones of high indigenous concentration, in the I region, the tuberculosis rate in Aymará is nearly two times higher than the tuberculosis rate at national level. In the XII region, the tuberculosis rate in Puerto Edén where 90% belongs to an indigenous group, the rate rises up to 46.8 as compared to the national rate of 20,3 for the year 2001 .[25]

> **Undernourishment:** There is no epidemiologic data on indigenous population.

> **Diabetes, obesity, alcoholism:** There is no epidemiologic data, partial studies based on cases show an increase in diabetes.

> **Suicidie:** Suicide rates are lower among the mapuche population compared to the national average[26] .

> *Intra-family violence (VIF):* In the IX region, VIF prevails in 55% among the mapuche population and 45% among non-mapuche population (SERNAM. Detection and analysis of VIF prevalence. Santiago, 2001).

Comments

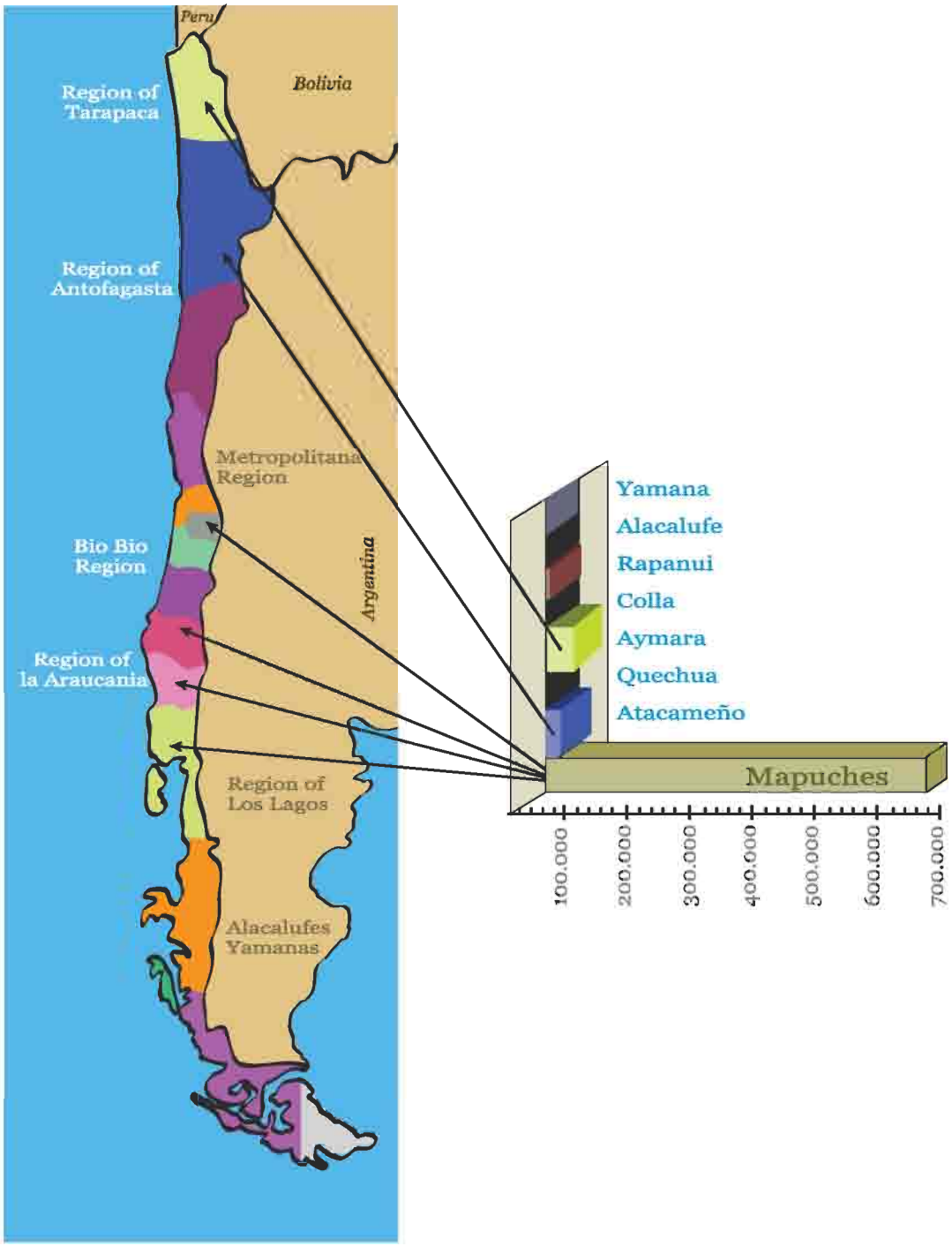
This report is a brief synthesis of the work carried out over ten years in Chile. During this time, our country has experienced a process of cultural change concerning health and the indigenous world. The report aims to present a vision of the processes and background collected during a short timeframe, in response to a request from the Pan-American Health Organization, on the occasion of the International Decade Evaluation of the World's Indigenous Peoples.

The document has been prepared by a work team integrated by: Margarita Sáez, in charge of the Health Unit for Indigenous Peoples of the Ministry of Health; Yolanda Nahuelcheo, representative of the mapuche people and Coordinator of the Intercultural Health Component of the Regional Health Secretariat of the IX Region and Dr. Christian Darras, Consultant representing Chile in the PAHO/WHO and Focal Point of the Indigenous Peoples Health Initiative.

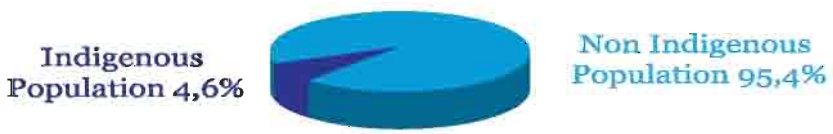
It has to be said that an important amount of the information given comes from diverse evaluations carried out during the various national, regional and local meetings, studies and workshops, between the indigenous world and the health sector. The meetings and processes have been documented, becoming reports, technical orientations, policies, programs and strategic plans; and they have been timely sent to the Initiative.

We thank for the opportunity and wish the greatest success in the development of the Organization's regional plans.

[23] UFRO et al, 1999. Chile's Mapuche Population. Analysis of the 1992 Population Census. Temuco, Chile.
[24] Oyarce, A.M. and Ibacache, J., 1998; Oyarce and Bustos, 2004. Sociocultural characteristics of Mortality caused by Pneumonia among Mapuche Children, 1996-2003. Unpublished document
[25] Epidemiology Project, Health and Indigenous Peoples Unit, MINSAL, 2004.
[26] Neira, J., 1998. Suicide rates among Mapuche and Non-Mapuche Population. Unpublished document.



Chile: Indigenous and Non Indigenous Population, 2002



Colombia

1. International Agreements and National Policies

International agreements	Legal frames		Technical units responsible for Health of Indigenous People	
	Constitution National Policies	Health policies	Governmental Instances Ministry	Contact Information
ILO Agreement 169, ratified by means of Law 21 of 1991 establishes the obligatory nature of the Colombian State to extend the social security regime to indigenous and tribal people. The law also adapts itself to their cultural conditions and ensures that their organizations and services are provided under the direction of its people, respecting its territory. Resolutions: CD37.R5 (1993); CD40.R6 (1997) of PAHO	**Political constitution of 1991 Article 7.** The State recognizes and protects the ethnic and cultural diversity of the Colombian nation. **Law 100 of 1993.** creates an Integral Social Security system. It ensures a compulsory health plan (POS) for all inhabitants of the national territory. **Law 715 of 2001.** . Article 83 defines the distribution and administration of resources for Indigenous Reserves, among them; basic health needs, and affiliation with the Subsidized Regime. **Law 812 of 2003.** approves National Development Plan 2003-2006, "Towards a Communitarian State", that states that schemes of agreement with indigenous and afro Colombian communities for improvement of their life conditions.	**Decree 1811 of 1990.** regarding the provision of free services for indigenous communities, institutional adjustment and human talent, respecting its culture (still in force). **Law 691 of 2001.** regulates the participation of ethnic groups in the General System of Social Security, in worthy and appropriate conditions, respecting the cultural diversity of the nation and its styles of life, protecting their rights for health and guaranteeing their cultural integrity. **Agreement 244 of 2003.** defines the form and operation conditions of the Subsidized Regime. It gives priority to natives as beneficiaries of the regime through the presentation of census listings elaborated by traditional authorities, as established in Law 691/01. **To Circular 018 of 2004.** establishes that when there are duly recognized ethnic groups the formulation of PAB must include the consultation program and agreement that establishes current regulations oriented to the ethno cultural adjustment of the actions to perform.	> Equity and Gender Group, General Direction of Social Promotion, Ministry of the Social Protection.	> Gina Carrioni Bogotá D.C. Tel (571)336-5066 ext.1236 E-mail: gcarrioni@minproteccionsocial.gov.co

Note: The information submitted is an excerpt of a document prepared by the country.
This document is kept in the records of the Health Program f Indigenous Peoples of the Americas in the PAHO headquarters.

2. Strategic alliances and networks of interinstitutional and intersector collaboration

Agreements of Indigenous Health Program.	> Agreement 221 of 2003 between the Social Protection Ministry and PAHO prepares a proposal of guidelines for social protection matters for ethnic groups of the country.
Inter institutional / intersectorial projects of the Indigenous Health Program.	> Project: definition of criteria and input needed for preparing guidelines of policy in social protection matters for ethnic groups located in border zones and in conditions of displacement. > Project: Analysis of Health Situation in Colombia. Agreement for technical cooperation between the Social Protection Ministry, the National Health Institute and the National University. It intends to collect, process and analyze data from different sources of health sector, territorial entities and other sectors providing socio demographic information regarding native populations.
Multi country	> Project of technical cooperation among countries: "Systematization and exchange of experiences in the organization and management of decentralized health services for indigenous populations Colombia-Ecuador". Organizations include the Pan-American Health Organization, the Ministry of Social Protection, the Main directorate of Social Promotion, the Departmental Secretariat of Health of the Cauca, the Association of Indigenous Town halls North of Cauca, the Colombian Ministry of Public Health, the National Direction of Indigenous Affairs, the Provincial Direction of Health of Imbabura and the Health Area of Cotacachi, Ecuador.
Inter institutional intersectorial forums.	> Discussion form in Web page: www.etniasdecolombia.org, coordinated by Hemera Foundation. > National work group of the project: "Water supply and Basic Sanitation for indigenous populations of Colombia".
Indigenous organizations that include integrated actions of health in their political agendas.	> Indigenous National organization of Colombia (ONIC). > Indigenous Movement Authorities of Colombia (MAICO). > Organization of Indigenous People of Colombian Amazon Region (OPIAC). > Indigenous organization of Antioquia (OIA). > Indigenous Zonal organization of Putumayo (OZIP). > Association of Indigenous Town halls of the North of Cauca (ACIN).
Networks	> Network of Indigenous Health of Amazon Region (REDSIAMA).

3. Primary attention of health and interculturality

Policies that promote the indigenous incorporation of perspectives, medicines and therapies in the National Health Programs.	> Resolution 10013 (1981): is the initiative of Health Sectional Services that takes care of indigenous populations in the old national territories and establishes free health care. Respect of their political, organizational and administrative structures, values and traditions, and the creation of models to integrate native traditional medicine with western or specialized medicine. Later within the regulation of Law 10 of 1990, Decree 1811, 1990 was issued. It was a landmark for indigenous communities orienting the later legislation until it became Law 100, 1993 and its regulations. > Law 691, regulates the participation of ethnic groups in the General System of Social Security in worthy and appropriate conditions, respecting the cultural diversity of the nation and their ways of life, protecting their rights in health and guaranteeing their cultural integrity. > Health Program 2002-2006 of the Social Protection Ministry that among other goals, raises an ethnic process of socio cultural adjustment of the General System of Social Security in Health to the particularities of Indigenous People and groups. > Social Protection System identifies and implements, when needed, strategies of reduction, mitigation and overcoming of risks arising from natural and environmental sources, social, economic and related to the market, vital life cycle and health (Decree 205 of 2003 determines the objectives, the organic structure and the functions of the Social Protection Ministry).
Experiences of harmonization of indigenous and conventional health system	> The Sectional Health Service of Vaupés has conformed and consolidated external teams for health promotion that act as companion and advisers of natives in the cultural adjustment of attention. > Organizations for the Promotion of Indigenous Health (EPSI): at the moment there are seven (7): Association of Town halls of the Defense of Zenú Indigenous people of San Andrés de Sotavento MANEXKA EPS with seat in San Andrés de Sotavento (Cordova); Association of Indigenous Town halls of Cesar and Guajira DUSAKAWI EPS with seat in Valledupar (C); ANAS WAYUU EPS with seat in Maicao (Guajira); Promotional organization of Health PIJAO HEALTH EPS with seat in Ibagué (Tolima); Promotional organization of Health GUAITARA EPS with seat in Ipiales (Nariño); Indigenous association of the Cauca AIC EPS with seat in Popayán (the Cauca) and Promotional Organization of Health MALLAMAS EPS with seat in Ipiales (Nariño, that had a continuation to December 2003, 331,208 places for natives and with extension of 333,562 places for 2004, for a total of 364,770 of the 546,442 places for natives appearing in the data base of the Social Protection Ministry.

Associations of indigenous therapists.	> CARARE Foundation. A non-governmental organization, founded in 2003 with the purpose of strengthening the well-being and quality of life of human beings and communities, specially the most vulnerable ones and the environment from a spiritual orientation with all the cultural knowledge, scientific and technologic disciplines and possible fields of action with no distinction of sex, race, national or family origin, language, religion, public or philosophy opinion and within the free of cults as stated by National Constitution.
Training and development program of human resources (Research and scholarships).	> From 1995, training of promoters selected by communities > Through Program of Health Care for Indigenous Communities of the Health Ministry, agreements have been entered with indigenous reserves in order to develop indigenous health centers and training workshops were developed on the basic elements of the Social Security System. > Health School of the Association of Indigenous Town halls of the North of the Cauca (ACIN), where indigenous health promoters of municipalities and reserves are prepared.

4. Information, analysis, monitoring and management

Information on the demographic, socioeconomic and epidemiologic profile of Indigenous People.	> Census 1993. > Non official technical document prepared in 2002 by the former Direction of Ethnic Matters, attached to the Direction of Public Health of Health Ministry. > Document "Characterization of the situation of indigenous population within the framework of the General System of Social Security related to Health". > Document as per Agreement 221 between the Social Protection Ministry and PAHO (2004). > Epidemiologist Profile of the Vaupés department
Information systems, monitoring, health evaluation of Indigenous People. It includes ethnic variable.	Information systems are a weakness in the health system they do not register the information regarding Indigenous People and other ethnic groups. They do not register the activities of traditional medicine and they do not have specific data that enables them to determine the main causes of morbid mortality because the information system does not include the variable of ethnicity.
Maps of location of Indigenous People in the countries as per political division of the country (Include map in the annex)	Map of the book "Indigenous People of Colombia" published by DNP in 2004 (Attachment). *(page.131)*
Characterization of Indigenous People with respect to their life and health conditions, social organization and health maintenance and restoration.	Document as per agreement 221 between the Social Protection Ministry and PAHO (2004).
Periodic publications on health of Indigenous People.	Newspaper Ethnic News. Newspaper Indigenous Unit (ONIC).
Section on health of Indigenous People in the Web Page of Health Ministries, PAHO or other institutions (electronic address).	http:/www.redsiama.org http:/www.col.ops-oms http:/www.etniasdecolombia.org

Second part

1. **What are the most important achievements in the health care of Indigenous People in the 1995-2004 period?**

2. **What are the high-priority problems in the health care of Indigenous People in 1995-2004 period?**

3. **What are the aspects to be considered in the insertion of the health of Indigenous People as a priority in the processes that the country is promoting in the renovation of Strategy of Primary Care and in the fulfillment of the Millennium Development Goals?**

Strategic analysis	
Strengths: particular characteristics of the country that facilitate the improvement of Indigenous People's health.	**Weaknesses:** negative aspects inside the country that make it difficult to improve the health of Indigenous People.
> The constitutional development, legislation and responsible regulation of the rights of Indigenous People and other ethnic groups. > The recognition of Indigenous People as collective subjects with rights and the recognition of differential treatment in the implementation of policies directed to the satisfaction of such rights > Social Security in Health: a) Indigenous People have been included in the scheme of social security in health; b) A conception has been developed for the well-being of ethnic groups; c) There exists abundant regulations dealing with health themes and regarding the model that creates the basis for implementing a model of care, and the development of inter- cultural understanding; d) There is a recognition of the rights of these groups to participate in all processes; e) Regulations dealing with administration and financing of indigenous ARS.	>Current regulations have not obeyed the consultation process or developed an integral policy in health matters for indigenous people and other ethnic groups. But, such processes have been somewhat responsible for claiming actions promoted by indigenous people; >There is no integral policy assuming the right to health as an indispensable human right for the efficient performance of rights of ethnic groups; >There is a tendency to assimilate indigenous people to sectors with great vulnerability; >There is no possibility of a budget or the money is not sufficient to cover obligations derived from regulation spirit; >There is a decentralization policy that has no practical application for the territories of indigenous people; >In spite of constitutional and legal provisions that oblige the State to fulfill the rights of indigenous people, the lack of political will and cultural limitations remain obstacles.
Opportunities: factors that are in the context, and are thought to act in favor of actions tending to improve the health of indigenous people.	**Threats:** negative factors that affect the improvement of the health of Indigenous People.
> For effects of universal coverage the State must allocate more human, financial and logistic resources, especially for regions with disperse populations and with difficult access such as jungle areas and plains with minimum attraction for the market of Entities Providing Health and (EPS Institutions Providing Health (IPS);	>Loss of territory, destruction of natural resources, decay of environment and illicit crops; abrupt socio cultural changes associated with the increase of contact and inter action with the social environment; progressive abandonment of traditional medicine and its commodification; difficulty of access to services of facultative medicine and insecurity of these services in ethnic territories; poverty and social and geographic marginalization, armed conflict.

Strategic analysis

> The application of an intercultural focus that includes mutual recognition and cooperation on the basis of respect, recognition and valuation on health and where there is a guarantee of selecting either facultative or traditional medicine;
> Studies regarding ethnicity and health sciences are important, particularly with the study of traditional medicine and the training of professionals that value dialogue and interact with agents of traditional medicine;
> Participation of the community in health proposals;
> The recognition of the cultural diversity and multi cultures of the Colombian population in the field of health. Understanding of diverse traditional ways of handling health and disease with a rationality that differs from the scientific parameters of facultative medicine. The right of identity and the obligation of the State to protect cultural diversity also implies the recognition of other traditional medical systems and its articulation to the national health system as alternative options that contribute to the performance of health rights. The tendency of health derived from multi- cultures is towards medical pluralism.

> In terms of risks related to health in indigenous communities, the category of disease should be understood as a rupture of equilibrium from the laws of ancestors;
> Regarding risks derived from the social security system:
a) indigenous people have been designated by the public system as groups with low income levels and high degrees of vulnerability, neglecting any considerations related with cultural particularities and special health themes;
b) there is an inadequate incorporation of institutional medicine in indigenous communities;
c) there is commodification of health;
d) inadequate incorporation of intercultural focus in health matters;
> Regarding risks derived from environmental factors there is:
a) deficient basic sanitation;
b) indiscriminate exploitation of natural resources
c) fumigation of licit use of crops and risks related with the alteration of these substances produced on crops and the environmental impacts of natural parks which in many cases coincide with territories inhabited by indigenous communities.

Third part

Table 1. Population and Indigenous Peoples of Colombia (population in thousands of inhabitants)

National population	Indigenous population (estimate)	%	Peoples
43.000	877	2,04	82

Source: DANE on basis of projections of 1993 Census; DNP on basis of 1997 cut - Accumulated to June 30th.

Table 2. Challenges, factors to consider and inequities (part 1)

Challenges

Health and public health strategies should be understood as well as the structural factors of risk and be inserted in the strengths of indigenous peoples:

A document published by DNP (2004) indicates that it is necessary to improve the communitarian infrastructure of services of the indigenous communities mainly in health, education, production, recreation and sports. It is urgent to focus attention on indigenous communities, widening coverage of immunization and protection to young populations and to develop programmatic lines oriented to improve and consolidate economies of indigenous territories, taking into consideration the sustainable use of natural resources and the strengthening of systems of food safety.

Likewise, it is important to customize health systems to indigenous lives and needs:

> The right to exercise one's own medical institutions;
> Access to institutional medical services;
> Access to preventive institutional health, mainly for children and nutritional observation;
> Training of human resources in institutional medicine;
> The management and administration of institutional medical services provided within indigenous territories;
> Recuperation, maintenance and the fostering of medicinal orchards

> **Factors to consider**

> **Location:** natives comprise dispersed populations, being more prevalent in the forests and plains (Amazon, Orinoquía and Pacific) than in the Andean zone or the Coast. In general, indigenous population have important weight in regions where jungle and natural plains biomass prevail such as the Baudó Serrania in the Pacific Litoral; the La Guajira Peninsula; the northeast of the Cauca Department at the south of Los Andres and the Sierra Nevada de Santa Marta. In other regions, indigenous people live scattered in small communities or in areas where mestizo farmer populations predominate. Indigenous people in all national territories are located in locations or communities and mainly in reserves (located in 29 departments of the country and the Capital District of Bogota) occupying 695 reserves, 70 of which are of colonial origin and 448 constituted by the INCODER in rural areas. There are Departments as Vichada, Vaupés and Guainía where 70%, 90% and 80% respectively of people are indigenous with different ethnicities, languages and cultures.

Table 2. Challenges, factors to consider and inequities (part 2)

> **Ethnic and cultural heterogeneity:** According to DANE, on the basis of projections from the 1993 Census data, indigenous populations are estimated at 743,899 people in reserves. If we add to this number those living outside of the reserves, the number reaches 132.781 indigenous people (data adjusted as of 1997 – ended June 30th, 2002). The total indigenous population in Colombia is about 876.680 persons, corresponding to 2.04% of the total national population of approximately 43 million inhabitants. Eighty-two Indigenous ethnicities have been officially recognized. The most numerous are the Wayúu (the Guajira), the Páez or Nasa (the Cauca), the Embera (including also the Embera Chamí and Embera Katíos) and the Pastos (Nariño). This is different from the above figures with approximately 40 ethnicities with less than 1.000 people each. These people speak 64 different languages, pertaining to 22 linguistic families. Contrary to the above, 40 ethnic groups have less than 1,000 people each. These communities speak 64 different languages, belonging to 22 linguistic families.

Inequities

Poverty: The real dimension of poverty is unknown in indigenous populations as current methodology has an urban bias (DNP, 2004). Several studies indicate that indigenous people are quite vulnerable to diseases and epidemics. Therefore, they have historically faced dramatic demographic crises and recently the Nukak were isolated in the Amazon Jungle in 1988. In 15 years this community went from 1.500 to 400 people. Indigenous morbid mortality is characterized by diseases associated with poverty (Document product of Agreement 221, 2004).

> **Illiteracy:** According to the 1993 census, from the total indigenous population surveyed (405,187 people), 78.6% speak Spanish, 21.4% do not speak it and 27,3% speak it as their main language. Bilingual populations older than 5 years that speak Spanish and an indigenous language are 51,2% and 9,6% is monolingual in indigenous languages. Those indigenous children older than 5 years that speak Spanish (318.458) are 33.4% and represent 59,8% of the total of this population. However, they do not know how to read or write in Spanish. From these people, 32.4% live in rural areas where 96.1% of the total of the population older than 5 years live. The indigenous illiterate population is 196.221 people, corresponding to 24,7% of the total indigenous population and 0,37% of illiterate people in the country that are 12,7% of the total national population. Most of the ethnic groups have illiteracy levels higher than 20,1%. The bara, coconuco, coreguaje, desano, guanaco, cañamomo, kamentsa, matapi and okaina groups have illiteracy rates of 10,1 and 20,0. The ethnic groups with a rate of illiteracy under 10 are the muisca and taiwano. The makaguaje group only registers one person (Document published by DNP 2004). Today, almost all indigenous speak Spanish, mainly in the Andean zone, even though there are difficulties and few methodological developments for teaching Spanish as second language. Some initiatives put emphasis on teaching in the mother language but without an in-depth revision of education contents.
There exist concerns for the loss of cultural references in indigenous children. In a recent report done by the Rafael Pombo Foundation in Association with Save the Children (2002) among the groups Muisca from Cota, (Cundinamarca), the Pasto from Potosí, Cordoba and Zuras (Nariño) Embera Chami del Alto Cauca (Marsella y Risaralda) Paeces and Guambianos of Santa Leticia and Silvia (Cauca) and the Pijao from Coyaima and Natagaima (Tolima) it was revealed that indigenous children are gradually losing the cultural bases and foundations of their people.

Table 2. Challenges, factors to consider and inequities (part 3)

Research shows that 96% of kids attended school or high school. Most of the respondents did not know the origin of their people (65% of those responding). Among kids that knew about their ancestry, teachers were in the second place as transmitters, after the parents. Additionally, the survey remarked that language has been lost as 77% of indigenous children responding do not speak the language of their ancestors.

> **Unemployment / employment:** According to a Census dated 1993, when analyzing the division of work by sex, activities men fundamentally participate in: agriculture (58,2%), study (13,6%), livestock breeding (6,6%), a diversity of work (16.9%) and nothing (4,9%). Women take care of the house (56,4%), participate in agriculture (31.7%), study (11.9%), are artisans (6.8%) do different work (6.7%) and do nothing (4.6%).

From the point of view of distribution of occupations by area, in the municipal government center where 3,3% of men older than 10 years are located, 28.9% are dedicated to agriculture, 25,3% to study, 9,8% do nothing and the remaining 36% engage in different activities. 3.7% of those in the municipal government center entertain different activities, as home 48,2%, 21.7% studies 8,3% agriculture and the balance to different things.

Out of the indigenous population older than 10 years old, men are dedicated to agriculture (59.2%), to study (13.2%), livestock breeding (6.8%), nothing (4.8%), hunting and fishing (3.1%) and different activities (13%). Women are dedicated to house work (56.7%), to agriculture (13.9%), to study (11.9%) and the remainder do different things.

In accordance with the type of activities entertained by departments, agriculture is performed by all indigenous groups. At a national level 36,2% engage in agricultural activities and at the rural level 98,3%. Agriculture is typically performed by men (79,9%). Home activities constitute the most important occupation in which 93% of indigenous women participate on a national scale. This is an activity where the majority of men participate in the Magdalena department (13.4%). 12.7% of the indigenous population older than 10 years study. Male participation in this activity is superior to women's, except in Magdalena and Caqueta.

Handicrafts complement the indigenous economy. However, it is performed by only 4% of the population. Male participation is low (16.6%) and it is mainly performed by women. Exceptions are in the departments of Vaupes, Guaviare and Tolima where more than 60% is entertained by men. In Amazonas and Vichada, men and women participate on equal levels.

Livestock breeding is performed by 3,6% of indigenous people and it is an important source of livelihood especially for the wayuu population. This labor is performed mainly by men. Hunting and fishing are activities performed by 1,7% of indigenous people in the departments of La Guajira, Guainía, Amazonas, Arauca and Vaupés. It is essentially a male activity except in the Sucre department where it is done by men and women.

Mining is an activity that 9.8% of indigenous people perform. It is mainly undertaken by men (76%). In El Choco, 88% of women participate in mining activities.

Teaching is done by 0.7% of the indigenous population and mainly in rural areas (91.3%). The departments with the most indigenous teachers are Cauca (600), Guajira (296), Nariño (178), Vaupes (153) Putumayo (119), Vichada (116), Chocó (114), Amazons (110). It is oftentimes a male profession but in La Guajira, Tolima, Norte de Santander, Casanare, Huila and Santander it is mainly undertaken by women.

Commerce is a secondary activity (0.7%) compared with the others. It is mainly done in rural areas (88.3%). In general, it is a male activity. However, in el Meta men and women perform it and in Arauca it is a predominantly feminine endeavor. Building among the activities only represents 9,3%. It is eminently rural (88.2%) and it exclusively performed by men. The exception is Risaralda where female participation is 37,5% and Antioquia 16,7% and Choco 25%. In health areas, 9.2% of the indigenous population participates. This is performed by men or women.

Table 2. Challenges, factors to consider and inequities (part 4)

Transport represents 9.27% of the total activities. This is an activity performed mainly by men (98%). Wood extraction is only undertaken by 0,2% of indigenous peoples at the national level and remains a male activity. Indigenous people with pensions or retirement plans constitute only 0,1% of the population and the main beneficiaries are men.

> **Utilities:** As per the 1993 Census, 70,8% of indigenous dwellings in national territories lack electricity. Indigenous people utilize different means to light their homes, including: burners (27,5%) or homemade lamps, beeswax candles (24.6%) and lamps or containers to store fuel as gasoline, gas, oil, etc (10.1%). Fuel for cooking is firewood in 80.9% of indigenous dwellings in rural areas.

Major water sources in indigenous dwellings include water from ravines or nearby rivers where liquid is carried by means of improvised or built installation. This type of provision accounts for 59,8% at a national level. Supplies from the aqueduct (which is predominant in municipal government centers) accounts for 25.2%. Water collection from service reservoirs, wells excavated in the ground are deposit for rain water or rivers correspond to 15,1% The collection of rain water from channels in the roof in tanks or drums installed in dwelling represents 5,2%. Water from a jaguey or dam where there is no circulation is 2,3%. In lesser measure, water in 1,9% is provided in wells where mills are used or in public wells with free access that 0,4% of dwellings use. 62,1% of indigenous dwellings dispose of garbage by throwing it into a ditch, yard or open sky lot. These types of practices account for 43,3% of dwellings located in municipal government centers and 62,8% in rural areas. 29,3% of indigenous dwellings burn or bury their waste. This is done in 29,5% of municipal government centers and 29,7% of rural areas. 66,5% of indigenous dwellings in the country do not have a system for the disposition of feces. 19,4% have a latrine or well with or without a toilet but lack circulating water; 11.4% of dwellings have an indoor washroom with water discharge and 2,6% directly deposit their waste it in a river ravine or the sea.

> **Infant mortality:** As per the 1993 Census, infant mortality rates have decreased. The rate of infant mortality was of 102,4 deaths of babies less than one year per every thousand born alive that year for the period 1981 1982; 95,4 per one thousand for 1983 – 1984; 91,7 per thousand for the period 1986 – 1987 and 91,1 per thousand of born alive for 1988 – 1989 which means that rates of infant mortality for 1993 was approximately 90 deaths per thousand born alive. These levels contrast with national averages for the same years at the following levels: 48,2, 43,6, 39,9 and 38,9 per thousand of born alive. The results stress that infant mortality in indigenous people is approximately three times higher than the national population and very close to the one observed in the Chocó department.

Difference by gender shows that mortality in boys is 22% higher than that of girls. The rates of infant mortality for indigenous children are as follows: 112,5% for years 1981 1982; 103,1% for years 1983 1984,; 100,3% for years 1986 1987 and 98% for years 1988 1989. For girls, it was as follows: 89,0% for years 1981 1982; 84.9 % for years 1983 1984; 79,2 for years 1986 1987 and 90,4% for years 1988 1989.

> **Maternal mortality:** An important aspect to highlight is the number of orphans in relation to children under 5 years of age (Data of 1993 Census). In certain indigenous groups it is very high. For example, in 1993, of every 100 indigenous children under the age of 5 in the Magdalena department, 10 did not have a mother. In Sucre, for every 100 children, 5 were orphans. In Santander and Arauca, 4 of every 100 were orphans. The departments where maternal mortality is under 1% are: la Guajira, Tolima, Amazon and Guaviare. In Caldas, Chocó, Meta, Huila, Valle del Cacua and Cauca every 2 children out of 100 are orphans, while in departments such as Casanare, Putumayo, Guainía, Vichada, Antioquia and Cordoba, 1 out of every 100 children under 5 are orphans.

Table 2. Challenges, factors to consider and inequities (part 5)

From a demographic study of 1998 that analyzed indigenous communities in three regions (Colombia and Tierradentro in the Cauca) the following conclusions were reached: The gross mortality rate was ten deaths per every one thousand inhabitants which is considered high for this population. The rate of growth (gross rate of birth rate minus mortality) was calculated as 31 per every one thousand inhabitants. Studies show higher female mortality In those children under four years old.

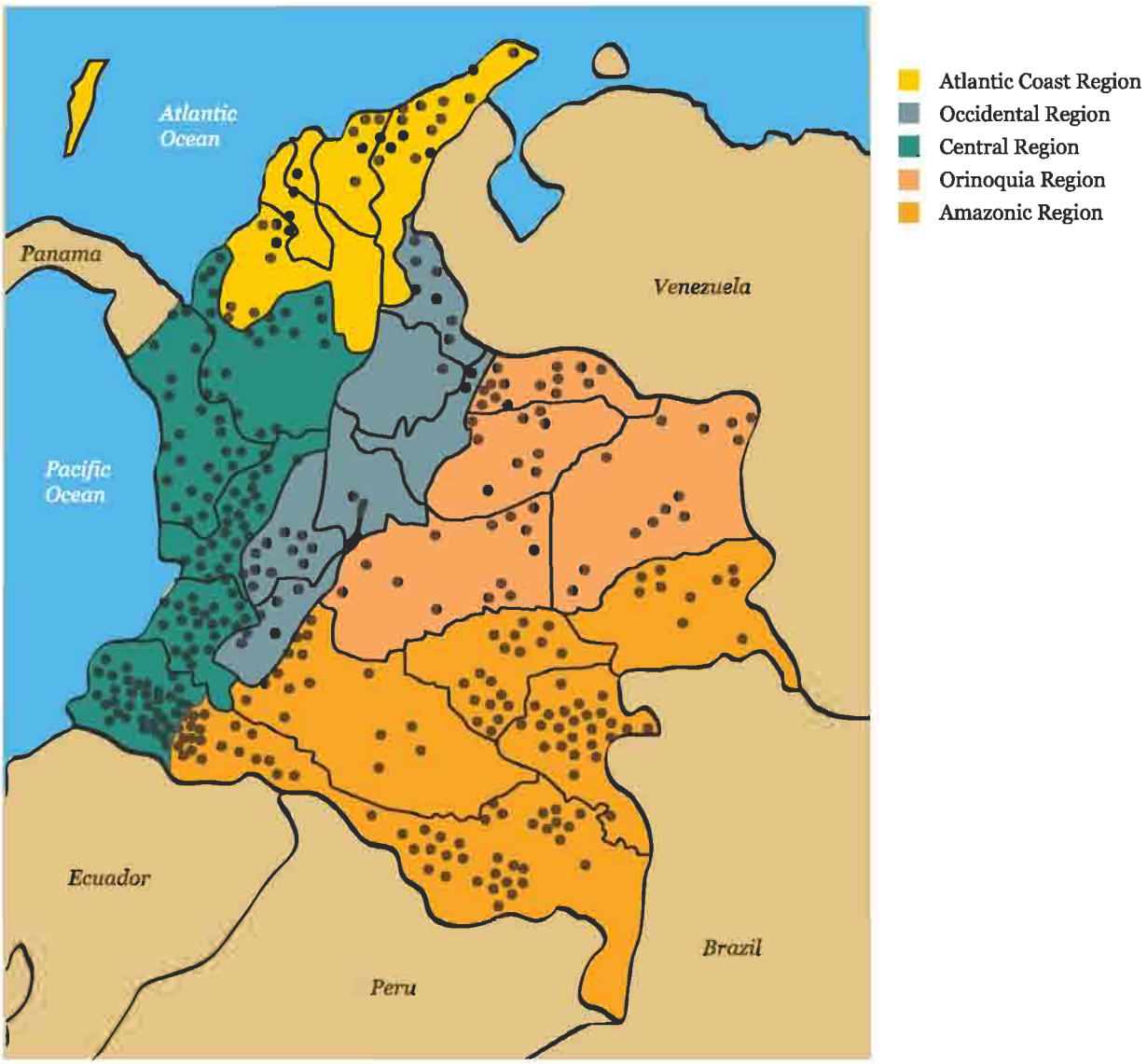
> **Undernourishment:** nutrition is varied, because many communities consume foods with low protein content, like rice, pastas, banana, etc., that were not previously part of their diet (Newspaper Unidad Indigena 1990)There is no specific evaluation, but there is a general opinion of undernourishment in the region; a phenomenon that specially affects childhood in communities with productive systems that have been altered by the expansion of illicit crops and violence (DNP, 2004)

> **Infectious diseases:** Equally concerning is the incidence of contagious diseases in indigenous communities. There is a high prevalence of diseases associated with poverty such as intestinal poli parasitism (PPI), acute diarrhea disease; diseases that seriously affect infants, acute breathing infections and tuberculosis. Specialists indicate that there are worrisome increases in cases of Hepatitis B and Malaria with a higher incidence of malaria cases due to Plasmodium Vivax and Plasmodium falciparum (DNP, 2004)

> **Diabetes, obesity, alcoholism:** (no data reported).

> **Suicide:** there are specific studies on indigenous mortality. Information can be inferred from the general situation in departments with a considerable indigenous presence. In those areas affected by violence and the expansion of illicit crops, homicides have an important place (DNP 2004).

Indigenous peoples of **Colombia**



Costa Rica

1. International Agreements and national policies

International Agreements	Legal Frameworks		Technical Units responsible for health of indigenous people	
	National Constitution Policies	Health Policies	Governmental instances / Ministry	Contact Information
Agreement 107, 1957 on indigenous and tribal people. Art: 19, 20 **International Agreement** on the Elimination of all forms of Racial Discrimination, New York, USA 1966 Art: 5. **Agreement No. 169** ILO on indigenous and tribal people in independent countries. Art: 7, 25, 30 Resolution CD37.R5/PAHO. Resolution CD37.R5/PAHO	**Political Constitution** of the Republic of Costa Rica, November 7th, 1949. **General Health Law: Nº** 5395, October 1973. Art: 1,2,3. **Law 3844.** Ratified in January 1967. Approves International Convention for Elimination of all forms of Racial Discrimination. Approves International Convention on the Elimination of all forms of Racial Discrimination. Article 5. **Law 7316,** November 1992, ratified in April 1993. Approves Agreement 169, ILO on Indigenous and Tribal People in independent countries. **National Development Plan.** Costa Rica 2002-2006.	**2002-2006 National Health Policy for Indigenous people.** Contributes to improvement of health conditions and quality of life for indigenous people starting with the development of plans, programs, projects and specific actions with inter cultural projects.	> "Technical Advisory Group of Health of Indigenous people" Health Ministry. Composed of representatives from institutions in the Health Sector such as the Health Ministry, Costa Rican Social Security, Costa Rican Institute of Aqueducts and Sewer System and Planning and Economic Policy Ministry. This is done with the auditing of Inhabitant's Ombudsman and the technical and financial support of the Pan American Health Organization.	> Ms. Xinia Gómez Sarmiento Direction of Health Development Health Ministry San José, Costa Rica Tel. (506)256-8248 Fax (506)256-8410 E-mail: xgomez@costarricense.cr

2. Strategic alliances and inter institutional and inter sector cooperation networks (part 1)

Agreements	> Agreement for integral development of health area among Costa Rican Social Security (CCSS), National Commission of Indigenous Affairs (CONAI) and Associations for Indigenous Integral Development (ADI).
National, Inter-institutional, inter-sector Projects.	> Project for the improvement of basic sanitation in schools on indigenous reserves Chirripó–Cabécar, 2004-2005 (Health Ministry, Costa Rican Social Insurance, Costa Rican Institute of Aqueducts and Sewer Systems, Inhabitant's Ombudsman). > Project of food security in indigenouss communities. Health Ministry/PAHO.
Multi Country Projects.	> Project of technical cooperation among countries, TCC Costa Rica-Guatemala-Panama, 2003. Basic sanitation in indigenous communities. > Project for strengthening that survey of inter border epidemiologic observation. Costa Rica/Panamá. > Project for basic sanitation in indigenous communities of the Bribri and Cabécar de Talamanca territories. Health Ministry/ Japanese Cooperation, 2004. > Project for technical cooperation between Costa Rica and Brazil. Strengthening of Costa Rican health model for indigenous health care. FUNASA/ Health Ministry, 2004.
Inter institution / inter sectorial fora	> Technical Advisor Team in health of indigenous people. Health Ministry. > National Working Group for the Project: "Water Supply and basic sanitation for indigenous population of Costa Rica".
Indigenous organizations that include health approach in their political agendas.	> **Regional Indigenous Association of Dikes (ARADIKES)** Indigenous non-profit organization General purposes: Improve the quality of life (socio- economic, cultural and environmental) of the indigenous population in Buenos Aires county. Objectives related with health include: strengthening health, hygiene and school recreation among indigenous communities with initiatives directed to combating diseases in the region. > **Iriria Tsochok Foundation (FIT),** Namasol Project. Indigenous non-profit organization with legal representation. Objects related to health include putting into context traditional indigenous medicine and the prevention of drugs and alcoholism. > **Foundation Tierras Unidas Vecinales por el Ambiente (Fundación TUVA).,** non- profit organization, with legal representation. Health activities include: support for the negotiation and implementation of local health programs by state institutions that respond to specific situations among the Ngöbe people with active participation. Support the strengthening of traditional medicine. > **Association for Integral Attention of Indigenous people.** non-profit organization. Health related objectives are: promoting projects to support the actions of the health team. > **Institute for the Studies of Sacred Traditions of Abia Yala (IETSAY).** non-profit organization, with legal representation. Objectives related with health include: emphasizing self-training of Sukias midwives and indigenous doctors. Undertaking exchanges with Ngobes traditional doctors and making agreements with other organizations working on this theme.

2. Strategic alliances and inter institutional and inter sector cooperation networks (part 2)

Indigenous organizations that include health approach in their political agendas.	> **Center for documentation of ethnicity (CEDOE).** non-profit organization, with legal representation. Objectives related with health are: strengthening indigenous medicine. GRASS ROOTS INDIGENOUS ORGANIZATIONS > **Association of Indigenous Women Cabécares (AMUICA).** IIndigenous organization, non- profit, no legal representation. Objectives related to health include: the fight against the disappearance of indigenous medicine. > **Association Commission of indigenous Bribri de Salamanca women (ACOMITA).** Indigenous organization, non- profit, no legal representation. Objectives related to health include: the fight against the disappearance of indigenous medicine. > **Cultural Association of Huetares De Quitirrisí Women.** Indigenous grass roots organization, non-profit, without legal representation. Objectives related with health: re-evaluate traditional medicine and spread it among indigenous and non indigenous people. > **Group Kekepa Salitre-Cabagra.** Indigenous grass roots organization, without legal representation, non-profit, gathering traditional doctors. Objectives related with health are: providing healing services and advice to indigenous families on the basis of indigenous natural knowledge. > **Teribe Cultural Indigenous association (ACIT).** Indigenous grass roots organization, non- profit organization with legal representation. Objectives related with health include: training and processing medicinal plants for public attention and finding self- financing for indigenous families.
Networks	**Indigenous NGO Network of South Pacific** Indigenous Organizations in the Buenos Aires County (south of Costa Rica), Objective: coordinate actions that promote the development of the region, promote the return to manipulating strategies of past decades that were previously discontinued: 1. Ska Diköl Association of Cabagra, 2. Center for Indigenous Development, 3. Association of Bribris de Salitre Women, 4. Regional Association Dikes Aborigens, 5. Committee of Artisan Women of Térraba, 6. Association of Mano de Tigre de Térraba Association, 7. Tribunal of Cabagra Common Law, 8. Association for Tourist Development of Térraba, 9. Association of Indigenous Artisans La Flor de Boruca, 10. Women Association with fight spirit of Rey Curré, 11. Association for Development of Indigenous Territory of Cabagra, 12. Association for development of Indigenous Territory of Rey Curré, 13. Association for the Defense of Terraba Indigenous Rights, 14. Association of Indigenous Women friends of Nature of Calderón de Salitre.

3. Primary health care and inter culture

Policies that promote the incorporation of indigenous perspectives, medicine and therapy in National Health Programs.	> National health Policies for indigenous people 2002-2003 of Costa Rica Health Ministry includes among its strategies: > The development of an awareness process for health officers that serve indigenous population on economic, social and cultural particularities; > The promotion of healthy traditional practices in health, agricultural production and indigenous medicine; > The opening of spaces for ample indigenous participation in analysis, research and design of strategies for solution of problems and health needs, and promotion of factors for health protection of this population.
Harmonization experiences of indigenous and conventional health systems.	**Program for indigenous integral attention /Costa Rican Social Insurance (CCSS).** Government, public institution. General objectives are: 1) promote health services with preventive and curative characteristics; 2) improve quality of life through integral health; 3) implement a health service specific for indigenous reality.
Association of indigenous therapists.	**AWAPA indigenous Association of Costa Rica.** Grass roots organization, non profit, with legal person (gathering traditional doctors). ***General Objectives:*** Strengthening practice of customs, indigenous knowledge and communitarian health ***Activities in health:*** Training for children, adolescents and women. Treatment of bronchitis, diarrhea, asthma, rheumatism, childbirth, snake bites and others.
Program for training and development of human resources (research and scholar-ships)	*Research:* > Institute for Health Research (INISA). > Costa Rica University > Institute on Alcoholism and Drug dependency (IAFA). > Costa Rican Social Security. *Training:* > Health Research Institute (INISA). > Costa Rica University. > Costa Rican Social Security > Institute on Alcoholism and Drug dependency (IAFA) > National Commission on Indigenous Affairs (CONAI) > National Commission on Prevention of Risks and Attention of Emergencies (CNE) > Association of Costa Rican Medical Services (ASEMECO), Biblic Hospital Clinic > Association for Integral Attention of Indigenous > Institute for Study of Sacred Traditions of Abia Yala (IETSAY) > Center for Documentation of Ethnicities (CEDOE) > Association of Indigenous Women of Cabécares (AMUICA) > Association of Costa Rica Indigenous Awapa > Association of Commission of Indigenous Women Bribri of Talamanca (ACOMITA) > Indigenous Cultural Association of Teribe (ACIT)

4. Information, analysis, monitoring and management

Information on demographic, socio economic and epidemiologic profile of indigenous people.	> National Institute of Statistics and Census. Population Census Costa Rica 2000. > Costa Rica University. Centro American Center of Population. ccp.ucr.ac.cr > Project State of the Nation. Annual reports. > Health Ministry. Direction of Health Monitoring. > Costa Rican Social Security (CCSS). File of hospitalization and deaths. www.ccp.ucr.ac.cr
Information, Monitoring and Evaluation Systems of indigenous people includes ethnicity variable.	National Institute of Statistics and Census. National Population Census www.inec.go.cr
Localization Maps of indigenous people in countries as per political division of the country (include map in the annex)	Attachment *(pagES. 144-145)*
Characterization of indigenous people regarding their life and health condition, social organization and systems of beliefs and values that have an influence in health maintenance and restoration.	> Project State of the Nation. Annual Reports. > Defense of Costa Rica inhabitants. Annual Reports. > Health Ministry. Direction of Health Development. Regional Directions. > Education Ministry. Department of Indigenous Education. > Work and Social Security Ministry. > Planning and Economic Policy Ministry. > National Commission of Indigenous Affairs (CONAI). > Culture, Youth and Sports Ministry. Project of Cultural Development in Indigenous Territories. > Pan American Health Organization . Costa Rica. > Ethnology Laboratory > Anthropology and Sociology School. Costa Rica University.
Periodical publication on health of indigenous people.	Bulletin of the Center of Indigenous Development (CEDIN). For general information, email: cedin@cedincr.org
Section on health of indigenous people in the web page of Health Ministry, PAHO or other institutions (email address)	No

Second part

1. What are the most relevant achievements in the health care of indigenous people between 1995 and 2004?

> National Health Policy 2002-2006 with specific guidelines and strategies to improve access and quality of the health care of indigenous people and migrant indigenous;
> Creation of the "Technical Advisor Health Team of Indigenous people" with the purpose of promoting, advising and supporting the organization and management of plans, programs and projects for improving the health and quality of life of indigenous people;
> Promoting the development of a health model with quality and inter cultural criteria;
> Starting a consultation process of the National Health Policy of indigenous people to the Association of Indigenous Integral Development;
> Commitment of Health Ministry/Costa Rican Social Security, for planning of actions based on policy strategies with inter cultural criteria;
> Course of inter culturality and health directed at regional and local level for the development of a work- based plan for indigenous culture and knowledge;
> Costa Rican Social Security (Service Provider): Promoting the participation of indigenous people: (Training of indigenous people as health promoters, the participation of communities in the Analysis of Health Status (ASIS) 2002-2006).

2. What are the priority problems in the health care of indigenous people between 1995 and 2004?

> Difficulty for indigenous populations and indigenous migrants to access quality health care that is timely and functional;
> Lack of observation of legislative health actions directed at indigenous populations;
> The health care model in the country is based on an institutional vision that does not consider particularities of indigenous populations;
> There is no mechanism that permanently incorporates indigenous populations in analyses of health situations and decision-making;
> Life conditions in indigenous territories maintain an epidemiologic profile with the prevalence of infectious contagious diseases and undernourishment;
> The current health system does not allow for the obtaining of comparable data and analysis that supports health surveillance in indigenous populations.

3. What aspects need to be considered in order to insert the health of indigenous people as a priority in the renewal of the Primary Care Strategy and fulfillment of the Millennium Development Goals?

> Development of a social communication strategy addressed at indigenous people on their health rights;
> Development of a training and awareness program for health offices with an intercultural focus based on respect of indigenous culture and knowledge;
> Opening of spaces for indigenous participation in the analysis, research and design of strategies for problem solving and health needs and the promotion of factors that protect health in this population;
> Improvement of health coverage in indigenous territories with emphasis on those of higher geographic isolation. Strengthening local resolutions and capacity in health and promotion of indigenous communities by training local personnel, formulating primary care and urgency protocols and planning care and promotion visits;

- Promotion of traditional healthy practices in food, agricultural production and indigenous medicine.Introduction of specific work addressed to indigenous populations as per the legislation in the operative planning of each institution;
- Binational Coordination in all levels of management for the health care of migrant indigenous populations;
- Promotion of a physical infrastructure and sanitary tools;
- Development of an education training process to improve general sanitation in indigenous territories;
- Strengthening programs to face infectious and contagious diseases;
- Establishment of mechanisms that improve food security and epidemiologic surveillance of undernourishment in indigenous populations;
- Implementation of a system that responds to information needs for health surveillance in indigenous populations.

Strategic Analysis	
Strengths: particular characteristics of the country that facilitate actions directed at improving the health of indigenous people.	**Weakness:** negative aspects in the country that make difficult actions aimed at the improvement of indigenous people's health.
> A sole Social Security System with an ample coverage of health services; > Relatively small percentage of indigenous population (1.7% of total population); > Signatures of countries for international agreements that project the rights of indigenous populations; > National legislation in indigenous matters.	> Inefficiency and non effectiveness of the Health Care System and prevalence of access barriers for indigenous populations; > Lack of a state policy that gives sustainability to actions addressed to improve the health of indigenous people; > Lack of an intercultural focus in health; > Community participation limited by inter organizational relations of cooperation and conflict with CONAI, ADI, civil organizations and public entities; > Ignorance of public administrators, judicial officers and Indigenous people themselves about existing regulations for indigenous people;

Strategic Analysis	
	> Lack of definition of autonomous policies and leadership of indigenous people; > 58% of indigenous population is located outside indigenous territories.
Opportunities: contextual factors that are deemed to act in favor of actions aimed at the improvement of indigenous people's health.	**Threatens:** negative factors that affect the implementation of actions aimed at the improvement of indigenous people's health.
> National Development Plan 2002-2006 with specific policies for indigenous people; > National Health Policy 2002-2006 with guidelines and specific strategies for the improvement of access and quality of health actions; > Strengthening of indigenous themes in an international perspective.	> Constant Change of political parties in government; > Cultural loss of indigenous people (language, agriculture, traditional medicine); > The imposition of management and development models that are foreign and non consultative for indigenous people; > Indigenous populations only possess 57% of the lands they are entitled to; > The entry of foreign organizations with indiscriminate actions and no coordination among official health structures.

Third part

Table 1. Population and indigenous peoples of Costa Rica

National Population	Indigenous Population (estimated)	%	Peoples
3.810.179	63.876	1,7%	8

Table 2. Challenges, Factors to be considered and inequities (part 1)

Challenges

Health strategies and public health should face structural risk factors and include indigenous people. This includes strengthening indigenous participation in health and local resolution capacity in health care and promotion. Educational training is necessary in order to improve the general sanitary culture of indigenous people, improve food security and the epidemiologic overview of undernourishment of indigenous people.

Factors to be considered

> **Localization:** Even though there is indigenous populations exist in all the provinces of the country, more than three-quarters (77,4%) live in the Limon, Puntarenas and San Jose provinces and are concentrated in the Salamanca and South Pacific zones. Only 27.032 (42,3%) of the indigenous population live within the 24 indigenous territories. The remainder, 36.844 (57,7%), reside outside of this territory.

> **Ethnic and Cultural Heterogeneity:** Indigenous populations are grouped into 8 different indigenous groups (Bribrís, Cabécares, Bruncas, Ngöbes, Huetares, Malekus, Chorotegas and Térrabas or Telires). Bribrí, Cabécar and Ngöbe people represent 81,6% of the population in the territory. Current indigenous populations have inherited rich cultural traditions; they maintain different degrees of conservation, and possess different cultures, cosmo visions, traditions and language. 58% of indigenous people within the territory speak indigenous languages. The wide variety of plants, food, ceramics, handicraft and works suggest that Costa Rica was a territory where meso American and south American cultures converged.

> **Culturally adequate care:** The institutional answer to the needs and demands of indigenous populations are insufficient. The care model lacks indigenous specificity, and does not respect the dignity, traditional medicine or medical authorities. The measuring of essential functions of Public Health performed in 6 of 9 regions located development indicators of human resources "Perfection of human resources for provision of services adequate to socio cultural characteristics of users" in a medium inferior performance (26-50%) in five regions and minimum (0-25%) in the remaining.

Inequities

> **Poverty:** Indigenous people are located in the most depressed districts of the country with a social development index lower than 55. 92,4%, of Indigenous communities report shortages in comparison with 85,6% of non indigenous people that live in the territories. They suffer from social exclusion due to geographic, idiomatic and cultural barriers and marginalization from bureaucracy. Several researches have revealed that many indigenous people arrive in more serious conditions due to factors of geographical inaccessibility. Approximately 2.500 Indigenous, (10%) of indigenous populations are excluded in the zones of Alta Talamanca y Tayní, Telire and Ngöbes areas.

> **Illiteracy:** Average illiteracy in indigenous communities is 30%, compared to 4,5 % in the rest of the country. Among Cabécares, the average is 50% (in Telire 95%). Average schooling in indigenous territories is 3,6 years (and is less than a year in Telire, Alto Chirripó and Bajo Chirripó). Assistance for general, basic education of populations from 5 to 15 years within indigenous communities is 56% (non indigenous in the rest of the country is 85%). In the zone of Talamanca and South Pacific very few indigenous people finish school and only the exceptional attend university.

> **Unemployment:** 55% of men older than 17 years (Census year 2000), work in family agricultural activities. 35% of men from this group work in non qualified activities (agricultural laborer). Out of the territories, 50% of indigenous men older than 17 years were working in non qualified activities. Regarding unemployment, 24% of men older than 17 years out of indigenous territories do not perform remunerated activities and 11% of those within territories have not performed remunerated activities.

Table 2. Challenges, Factors to be considered and inequities (part 2)

> **Utilities:**

> **Dwellings:** As per the 2000 Census in indigenous territories, 79% of dwellings are owned, while, in non indigenous populations ownership of property is only 59%. Dwellings occupied by indigenous people on loans were 24% and 46% of dwellings occupied by indigenous people were owned.

> **Water:** 62% of dwellings occupied by indigenous people within territories do not have indoor water supplies, 23% of those occupied by indigenous people outside of the reserves and 8% of those inhabited by non indigenous people. The quality of water for human consumption is unknown. Water resources are 69% of rivers and ravines and 23% of rural aqueducts (2000 Census).

> **Disposal of Feces:** Dwellings with septic tank account for 21%, which is in contrast with the rest of the country (more than 90%). Likewise, dwellings within territories that have latrines represent 65% of the population. At a national level it is 97%.

> **Infant Mortality:** Even though infant mortality rates have decreased there still exists a discrepancy regarding national averages (17 and 7 respective in the period 1995-1999) In 2001, while the national average was 10.8 for every 1.000 born, in areas with more indigenous peoples rates were: Corredores 21,1, Talamanca 17,2, Coto Brus 17,1, Golfito 16, among others.

> **Maternal Mortality:** National maternal mortality rates are 2.56 per one thousand born alive. In the Turrialba, Buenos Aires and Matina provinces with indigenous populations, maternal mortality rates are 7.5; 11.0 and 12.1 respectively.

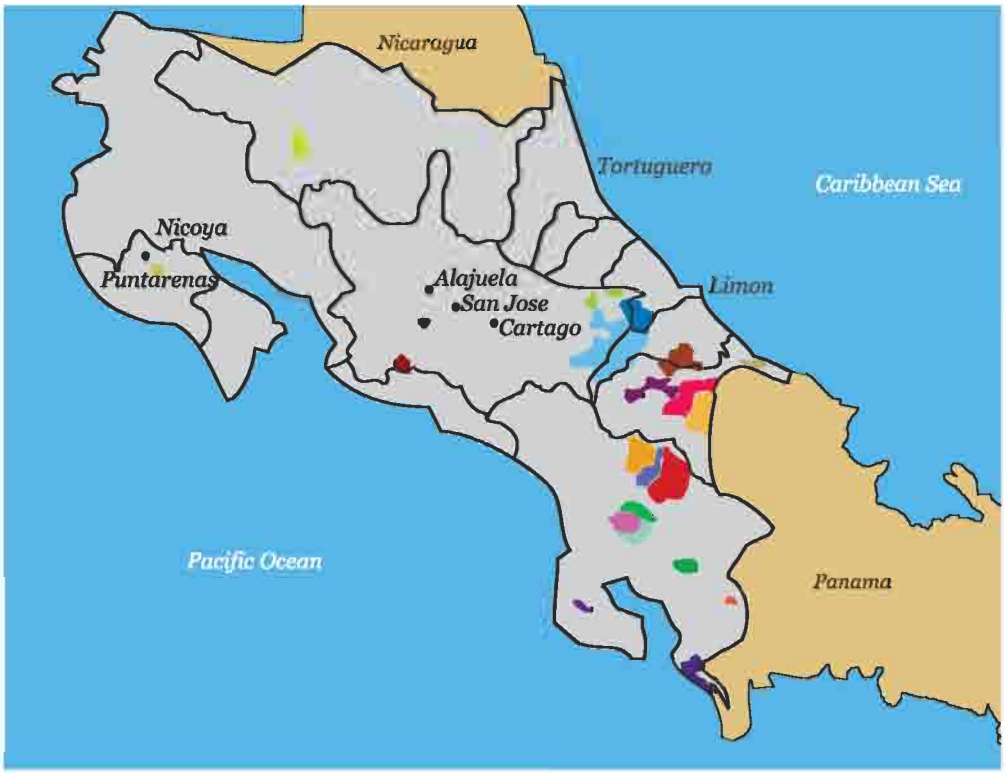
> **Undernourishment:** It is known that first grade students of districts with high indigenous populations show a delay in moderate height (16%) than those observed in the rest of the districts (7%).

> **Infectious diseases:** Deaths due to infectious contagious diseases are now equal to those caused by chronic diseases and traumatisms to a rhythm similar to that of national population. Even though the gap between both populations continue. In the five year period (1970-1974) deceases due to infection contagious diseases represented a rate of 63 for 10,000 inhabitants in the 7 districts with indigenous populations. In the remaining districts the number was 27. In the five year period 1995 -1999 rates were 24 and 10 respectively.

> **Diabetes, obesity, alcoholism:**

> **Suicide:** Rate of death due to accidents and suicide in the seven districts with higher indigenous populations need special attention. In the 7 districts with higher rates of indigenous people in the period 1970-1974 the rate was 9 and has increased to 17 for the period 1995-1999. In the other districts the rate remains constant at around 12 per 10.000 inhabitants.

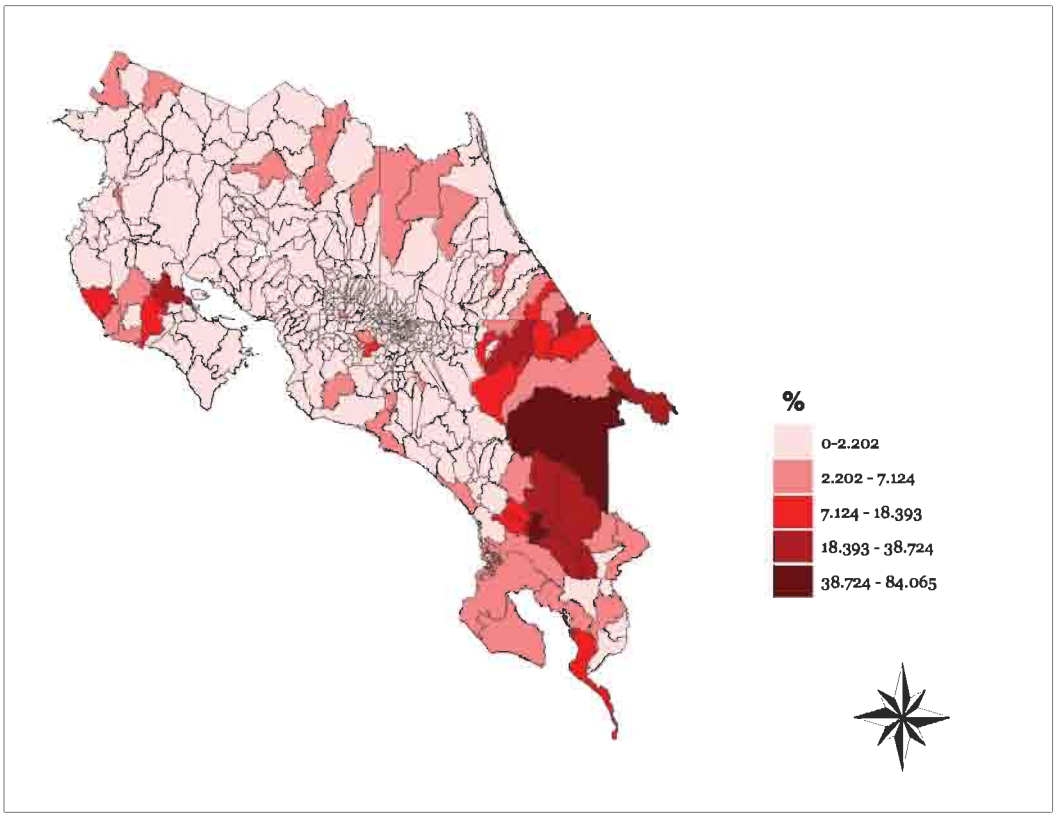
Indigenous peoples in **Costa Rica**



- Guaymi de Coto Brus
- Guaymi de Osa
- Huetar de Quitirrisi
- Huetar de Zapaton
- Bribri de Cabagra
- Bribri de Keköldi (Cocles)
- Bribri de Salitre
- Bribri de Talamanca
- Bunka de Boruca
- Brunka de Curre (Rey Curre)
- Cabecar de Bajo Chirripo
- Cabecar de Chirripo (Duchi)
- Cabecar de Nairi-Awari
- Cabecar de Talamanca
- Cabecar de Tayni
- Cabecar de Telire
- Cabecar de Ujarras
- De Guatuso
- De Matambu
- De Terraba
- Guaymi de Abrojos-Montezuma
- Guaymi de Conteburica

Indigenous population according to district and population density in **Costa Rica**

Census 2000



Comments

Information requested by PAHO in this evaluation is very important to demonstrate the existing gaps between national and indigenous populations. It provides elements for a better understanding of the problems and challenges faced by indigenous people and health planners. One of the principal limitations of the country regarding indigenous health is the absence of the variable of ethnicity in the registries of health institutions that makes it difficult to obtain timely and trustable information to characterize its health profile and guarantee health surveillance of this group. This factor was the main limitation for filling out this evaluation. This evaluation analyzes information that is not in one institution or organization and therefore demands contributions from different people and groups that work with indigenous populations, which was not obtained in most of the cases. Thus, this document should be taken as a preliminary version that is expected to be improved.

Xinia Gómez Sarmiento
Direction of Health Development

Dominica

1. International agreements and national policies

International Agreements	Legal Frameworks		Technical Units Responsible for the Health of the Indigenous Peoples	
	Constitution/ Policies National	Health Policies	Agencies governmental/ Ministry	Information contact
Convention 169 ILO (ratified in 2002); PAHO resolutions CD37.R and D40.R6	Carib people development plan (ratified by Cabinet in 2003)	Strategic Plan 2002-2006, MOHSS [36] The MOHSS developed an Action Plan 2002-2006 that identified Carib health as a priority[37] It states the following (p.21): *«Our programmes are aimed at moving the Caribs from a state of dependency, to where they become more involved in their own health care»*	> MOHSS > Department of Carib Affairs	> Patrick Cloos, CMO, Tel: 1(767)448-2401, 3521, 3258. E-mail: cmo@cwdom.dm > Dr. Charles J. Corbette Head of Department-Carib Affairs Tel: 1-767-4498132 Fax: 1-767-4486753 E-mail: caribaffairs@cwdom.dm

[36] Minister of Health and Social Security.
[37] Drug abuse, adolescent pregnancy, incest, violence and suicide were identified by the MSSS as priorities for the Caribbean region.

2. Strategic Partnerships and networks of interinstitutional and intersectoral collaboration

Agreements	> National Carib People Development Plan (2003).
National projects, interinstitutional/ interesectorial	> 1995-97: JNSP (Joint Nutrition Sponsored Program) funded a project to decrease malnutrition rate and worm infestation in the Carib Territory. Education was implemented by the MOHSS in collaboration with other sectors. At present, malnutrition seems to be rare. > Faith-based organizations, Canadian High Commission, Robinson TRUST (Culture & Health, based in UK), Ross University, and Martinique provided funds to build a hospital that will be located in the Territory. > Good News (Church organization): built houses, provided clothes and medical supplies and funded a workshop on drug prevention to which Kalinago health workers participated (2003); ongoing education followed; anonymous alcoholic group was formed. > Christian Children Fund: Roving care givers (home to home visit for children stimulation); provide supplies (re: education, medical supplies); lice program; home renovation; sponsor of children's education and educational activities. > Faith-based organization: sanitation project (1998). > DEREP (Dominican Environmental Rural Enterprise, Dominican NGO): funded agricultural projects in the Carib Territory (1998-99); > To eradicate anemia and pregnancy among teenagers, a nutrition program was developed by the Nurse & Health Promotion Unit (MOHSS), sponsored by Dominica National Counsel of Women (DNCW) and funded by ICA. > Drug Prevention Unit (MOHSS) is working in collaboration with a community-based organization located in the Carib Territory; > Dominican Plan Parenthood Association provides education re: HIV/AIDS and family planning.
Projects multicountry	**2003:** *Caribbean Regional Environmental Project* (CREP): proposals have been presented to CREP re: waste disposal (as of today no waste collection system in place). Sanitation proposals for the building of toilets facilities in the Territory are in process.
Interinstitutional/ intersectoral forums	> National forum for National Development with Kalinago-oriented component. > An International Indigenous Forum was organized in Dominica in 2000; some participants feel bigger countries dominated the debate and nothing concrete for Kalinago peoples transpired from this event.
Indigenous organizations that include health in its political agendas.	Wai tukubuli kari funa development agency (Waikada) funded by different sources. Cultural component.
Networks	There was a Caribbean Organization of Indigenous Peoples (COIP) that is currently dormant.

3. Primary health care and cultural diversity

Policies that promote the incorporation of the perspectives, medicines, and Indigenous therapies in the National Health Programs.	The health perspective of the Kalinago peoples is not taken into consideration, although there is a certain level of incorporation of their realities at a policy level. A more holistic approach to health should exist. Kalinago traditions and needs are expressed but not necessarily regarded. Traditional medicines should be incorporated in health policies. During the implementation of the PHC system (in the early 80's), the Carib Territory was shared within two health districts (Castle Bruce and Marigot). Consequences: there are difficulties in adapting to the situation for peoples, (Carib people share facilities with people from both surrounding villages) there is a lack of representation in one district, and disparities in terms of services.
Experiences of harmonization of the Indigenous and conventional health systems	See above
Traditional healers' associations	None
Training and human resources development programs (research and fellowships)	No specific program for Kalinago; No «affirmative action». A greater number of Kalinago people undergoing training are needed. There is a certain level of perceived discrimination to access work and fellowships, although recently, 6 students went to Cuba to study. At present in Dominica, there is 1MD and 8 nurses are from Kalinago origin.

4. Information, analysis, monitoring, and management

Information on the demographic, socioeconomic and epidemiological profile of the Indigenous peoples	Census-2001 (use of variable «ethnicity»); no epidemiological profile of Kalinago per se.
Information systems, monitoring, and evaluation of the health of the Indigenous peoples include the variable of ethnic group.	No use of variable «ethnicity» in the collection of data (Health Information Unit). Infectious diseases surveillance exists based on health services data from each district.
Maps of location of the Indigenous peoples in the countries in accordance with the political division of the country (include the map in the Annex)	No
Characterization of Indigenous peoples with regard to health and living conditions, social organization and systems of beliefs and values that influence the maintenance and restoration of health.	Census-2001 (use of variable «ethnicity»): data available re:- demography, education, income, employment, living conditions and housing.
Periodic publications on the health of the Indigenous peoples	No
Section on health of the Indigenous peoples on the Web page of the Ministries of Health, PAHO, or other institutions (electronic address)	No

Second part

1. Which are the most relevant achievements in the health care of the Indigenous peoples in the period 1995-2004?

> Primary Health Care services (started early 1980's): Maternal and Child Health/EPI/Family Planning; Environmental Health; Health Education; Medical care; dental services;
> Health education activities undertaken by NGOs (Dominica National Council of Women, Christian Children Fund, ICA, and ADRA) on child abuse, warm infestation, anemia during pregnancy, domestic violence, sanitation, STI/HIV/AIDS, and communicable diseases (TB);
> Students obtained scholarship to study medicine abroad.

2. Which are the priority problems in the health care of the Indigenous peoples of the country in the area national and subnational?

> 2002-2006 Strategic Plan (Ministry of Health and Social Security):
> Ambulance services for the Territory;
> Improvement of health care facilities;
> Health Promotion (family planning/teenage pregnancy/helminthiasis)
> Mental health (violence/ drug abuse /incest / suicide);
> Improvement of human resources
> Kalinago peoples:
> Lack of health care facilities/medical supplies;
> Lack of medical human resources;
> Environmental health (no solid waste collection in the Carib Territory; unsafe water supply;
> Poverty;
> Poor housing conditions;
> Lack of access to health care services in island (due to lack of transportation and financial resources);
> Carib Territory should be considered as a health district.

3. Which are the aspects to consider in the insertion of the health of the Indigenous peoples as priority in the processes that the country is promoting in the renewal of the Strategy of Primary Care and in the achievement of the Millennium Goals?

> Lack of medical supplies and medicines;
> Lack of trained nurses/health aids;
> Lack of medical equipment (mammography, ultrasonography, pap smear)
> Lack of environmental health support/resources/no solid waste collection;
> No public conveniences;
> Need for Ambulance;
> Lack of logistics (transportation for health workers);
> Needs to ensure access to health care services (equity);
> Poverty.

Strategic Analysis	
Strengths: characteristics specific to the country that would facilitate the actions aimed at the improvement of the health of the Indigenous peoples.	**Weaknesses:** negative aspects within the country that hinder the actions aimed at the improvement of the health of the Indigenous peoples.
> Primary Health Care Services. > Acceptance of health programmes by peoples. > Willing to learn new technologies. > Community able to identify their own health problems. > Willing to participate. > Willingness of NGOs to sponsor.	> Poverty and unemployment; > Beliefs of Kalinago peoples (related to medicines); > Improper health care facilities; > Lack of medical equipment; > Lack of medical human resources; > Lack of financial resources
Opportunities: factors that are in the context, and that will act in favor of the actions aimed at the improvement of the health of the Indigenous peoples.	**Threats:** negative factors that affect the implementation of actions aimed at the improvement of the health of the Indigenous peoples.
> Primary Health Care Services; > NGOs; > Hospitality of Kalinago peoples;	> Racism or negative attitudes towards Kalinago peoples. > Poverty. > Lack of Communication between Kalinago/non Kalinago

Third part

Table 1: Population and Indigenous peoples of Dominica

Categories	Kalinago territory
> Population	**2,208 (3,1%)**
> Ethnicity	**(self-reported)**
> Carib	**53%**
> Carib (island)	**2.9%**

Source: 2001 Census

Table 2. Challenges, factors to consider, and inequities

Challenges

Strategies of health and public health should include and address the structural factors, of risk and to be inserted in the strengths of the Indigenous peoples:

Factors to consider

> **Location.** Dominica was the name given to 289.8 sq. miles of land, by Christopher Columbus, when he landed on the island on November 3rd 1493. On the North Eastern side of this beautiful tropical rainforest island is 3782.03 acres of land known as the Carib Territory. It is situated between two villages, Atkinson to the North and Castle Bruce to the South, and is the home of approximately 2000 Caribs[38], the remaining survivors of the first inhabitants of the island. The Caribs called the island Waitukubuli (Tall is her body), and they called themselves Kalinago. The Europeans called them Caribs.

> **Ethnic heterogeneity and cultural**
Culturally appropriate care The Caribs being the first nations' people have struggled to survive since the arrival of the Europeans in 1493. They have lost most of their traditions, religious practices and language to European discrimination for well over five hundred (500) years. Most importantly, they have lost their freedom to travel freely throughout the islands. However, they have managed to retain certain aspects of their culture, which includes canoe building, basket weaving, cassava making and traditional medicine.

Inequities

> **Poverty** The Carib Territory has been very much neglected and has been identified as one of the poorest communities in the island. The just concluded Draft Country Poverty Assessment (CPA) for Dominica[39], recorded the incidence of poverty in the Carib Territory of over 70%, which is very high compared to what obtained at the national level. It was not until 1965 that a motorable road was constructed. The area lacks the most basic needs. The 1996 Country Poverty Assessment describes the Territory as having not only economic poverty but also a form of deprivation that *'stems from being a low status minority with a long history of neglect, loss of culture and struggling to keep their identity'*.

> **Illiteracy.** % attending school in the previous week: Kalinago territory 9%; non-Kalinago territory 10%

> **Employment rates**
% employed in the previous week of interview: Kalinago territory 55%; non-Kalinago territory 51%

Basic services	Kalinago territory	non-Kalinago territory
Type of water supply Water supply (public or private) into dwelling	2.3%	52.6%
Type of toilet facilities W.C. (flush toilet) Main toilet facility	4.6% Latrine: 90%	55% W.C.: 55%
Type of lighting Electricity Kerosene	56.3% 39.3%	90% 7%
Type of cooking facilities Gas Wood	34% 63.2%	81.9% 10%

[38] This is according to the Census from 2001
[39] Halcrow Group Limited. (2003). En el Banco de Desarrollo del Caribe& Gobierno de Dominica, Análisis de la Pobreza en el País: Dominica.

Comments

This evaluation was co-coordinated by Dr. Patrick Cloos, Chief Medical Officer, Ministry of Health and Social Security (MOHSS). Meetings were held with the following stakeholders: Dr. C.J.Corbette, Head of Department-Carib Affairs (PM Office); Dr. Worrel Sanford, Mrs. Warrington, Mrs. P. Thomas and Ms.Vigilant . Mrs. Joan Henry, Health Promotion Unit Director (MOHSS), and Planed Parenthood Association provided some input as well.

Participants had heard about the International Decade of the World's Indigenous Peoples, but without being fully informed of its objectives. Furthermore, participants are not aware of PAHO Resolutions CD 37.R5 and CD40.R6.

[40] Médicos y enfermeras Kalinago trabajando en el Territorio Caribe.

Ecuador

1. International Agreements and national policies

International Agreements	Legal Frameworks		Technical Units responsible for Health of Indigenous People	
	National Constitution / Policies	Health Policies	Government Instances / Ministry	Contact Information
Agreement 169. International Labor Organization (ILO) Resolution CD37. R5/OPS. Resolution CD40. R6/OPS.	**Constitution of the Republic** > Articles 4, 44, 84 > Mandate of indigenous people	**1999.** Creation of DNSPI. **2002.** Budget regulation and provision of human resources to intervene in 18 provinces of the country. **2004.** Development of strategic operative components, Institutional Corporate Development. Inter Cultural Health Models and Sub Systems of Ancestral and Traditional Medicines.	**National Health Direction of Indigenous People depending from the Public Health Ministry.**	> Dr. Juan Naula e-mail: Tel. 095-00-3345 > Dr. Germán Ochoa Dávila E-mail: G8davila.@yahoo.es > Dr. Guillermo Barragán Quito, Ecuador Tel. 09837-2354

2. Strategic alliances and inter institutional and inter sectorial cooperation networks (part 1)

Agreements of Indigenous Health Program.	> Agreement for bi national integration for development of corridors related to Ecuador / Peru Amazon space for the organization of models of integral attention and projects for native towns of the borders. Chancellery.
Inter institutional inter sector Programs of the Indigenous Health Program.	> Local experiences in APS and Food and Nutritional Safety in Saraguro People. > Training to demanding networks of Kichwa, Shuar nationalities in APS aspects. > Constitution of Council of Wise Men by nationalities and people. > Cultural and socio organizational validation of those mediating in traditional and ancestral medicines of nationalities and people. > Recovery of Sacred Geography CEE-France DNSPI. > Curriculum reform with intercultural focus in the pre degree in the School of Medicine, Central University of Ecuador. > Curriculum reform of Indigenous University of Indigenous People. > Restoration of the fito therapeutic botanical garden of Shuar nationalities of Zamora Province. > Common Monitoring with Intercultural Focus, pilotage in Amazonas province of Pastaza in seven nationalities.
Multi country projects.	> TCC-Colombia-Ecuador: "Systematization and exchange of experiences in the organization and management of de centralized health services for indigenous population". Cotacachi case in de centralized processes. > TCC Implementation of Intercultural Health System of indigenous people in Amazon Region. > TCC México > P1. Management of patents and intellectual right in intercultural health and indigenous biodiversity. > P2. Active principles and promising plants for the development of an alternative list of generics. > P3. Exchange system of knowledge and ancestral and traditional practices and of traditional medicine of indigenous people and nationalities.
Inter institution / inter sector fora	> First International Congress of Sovereignty and food safety and infant nutrition, November 2004. > Seminary Workshop "Advances in process for quality improvement and cultural adaptation of sexual and reproductive health services with inter cultural focus", November 2004. > II World assembly of health of people. > Preparation of the "III Congress for development of ethnics and health", June 2005. > I National Congress "Ancestral Medicine of Andean People". Loja 2005
Indigenous organizations that include health management in their political agendas.	> Confederation of Indigenous Nationalities of Ecuador (CONAIE), ECUADOR RUNACUNAPAC RICCHARIMUI > Confederation of People of Kichua Nationalities of Ecuador (ECUARUNARI), Confederation of nationalities > Indigenous of Ecuadorian Amazon Region (CONFENIAE), CONAISE, Group for Defense of Indigenous, Farmers and Negro People of Ecuador (FEDEPICNE), National Confederation of Indigenous and Negro Farmers (FENOCIN), and affiliates.

2. Alliances and inter institutional and inter sectorial cooperation networks (part 2)

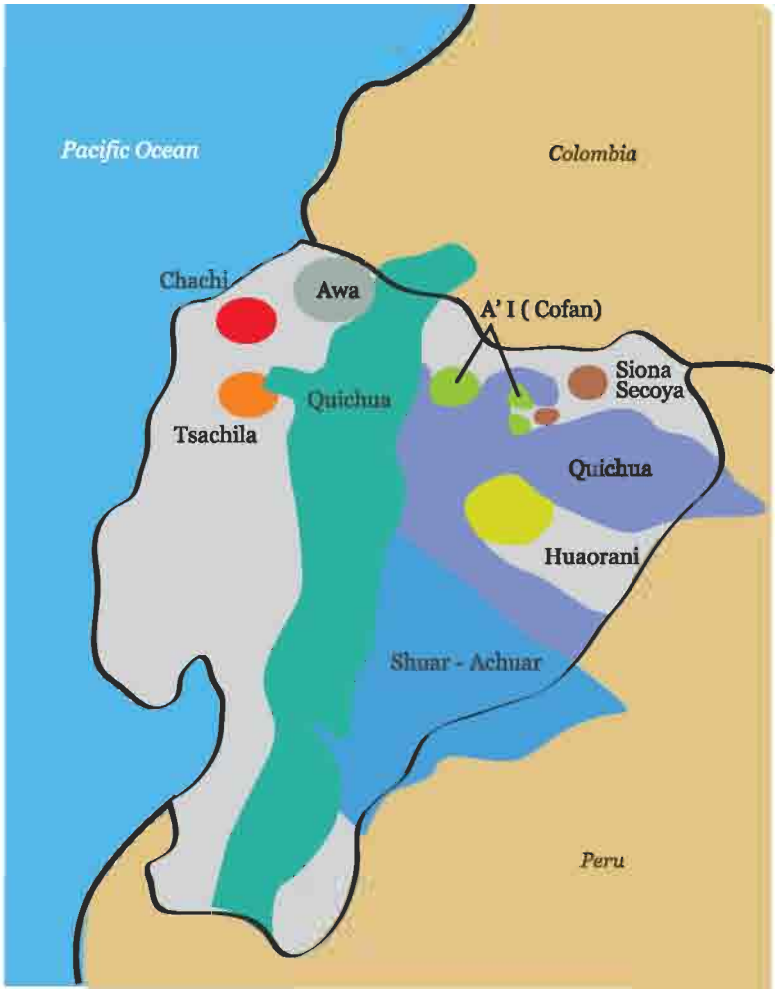
Networks	> Network of indigenous health of Pastaza, Amazon Region, Health Networks of Loreto in Alto Sucumbios and Orellana. > Intercultural health network Archidona – Napo. > Network of women leaders of UCCP, Cañar Province. > Network of mediators of ancestral and traditional medicine of people of Chibuleo, Salasaca, Pilahuin, Tomabela, Quisapincha of Tungurahua Province. > Network of traditional Imbayas midwives in cooperation with the Obstetrics School of the Central University of Ecuador.

Policies that promote incorporation of indigenous perspectives, medicines and therapies in National Health Programs.	>Policies and Strategies In sexual and reproductive health with inter cultural focus. >National Operative Plan of the maternal prenatal component with intercultural focus 2004. >Mandates of health policies and management models and inter cultural attention proposed by the Health and Life Congress, Ecuador September 2004. >Reforms to Health Code (incorporation of knowledge and practices of Indigenous Traditional Medicine) and inclusion of inter cultural focus in the articles of the Law of National Health Council. >Bill of Law of Traditional Medicine of Nationalities and Indigenous People of Ecuador in first Debate in the Honorable National Congress >Recognition of sacred spaces in territories of indigenous people incorporated in the Environmental and Biodiversity Law in second debate of Honorable National Congress. >Program for Extension of Coverage (PROECO) in parish of critical poverty by application of a model of integral attention with inter cultural focus for Health Areas of the Public Health Ministry. (MSP). >Second strategic reform for execution of health policies for people and nationalities of the Direction of Indigenous Health of MSP –2005-2009 Strategic Map (presently being published).
Harmonization experiences of indigenous and conventional health systems.	>Contributions for the First Integration Proposal for the Organization of Health Provincial System of Pichincha from the Provincial Council of Pichincha. >Creation of Council of Intercultural Metropolitan Health of Quito. >Intercultural health brigades en 18 provinces of the countries in places of inadequate access to services. >First experience of operative integration with undergraduate students of the School of Medicine of the Medical Science Faculty (Central University of Ecuador). >Incorporation of kichwa advisor and company to users of Indigenous Hospital of Chimborazo. >Experiences from inter cultural communication in media from the kichwa radial network, Pichincha. >Management of Intercultural Health Promotion in migrant kichwas people located in border of El Oro province.
Association of indigenous therapists.	>Precouncils of wise men and women of Indigenous Traditional Medicines in 18 provinces of the country. >Yachacs Association of Otavalo, Ecuador. >Foundation of Taytas and Mamas of Ecuador.
Programs for training and development of human resources (research and scholarships).	First Proposal for Master Program in Family Health with gender and intercultural focus (MODERSA MSP 2004).

4. . Information, analysis, monitoring and management

Information on demographic, socio economic and epidemiologic profile of indigenous people.	
Information systems, monitoring, health evaluation of indigenous people. Includes ethnic variable.	Base line proposal and first pilot plan of common monitoring with intercultural focus in Pastaza Province.
Maps for localization of indigenous people in countries as per political division of the country (include map in the annex).	Please refer to Information and Indicators Systems (SIISE), Ecuador chapter, to obtain anything related with dynamic and theme maps. (pag. 165)
Characterization of indigenous people regarding their life and health conditions, social organization and maintenance and restoration of health.	
Periodical publication on health of indigenous people.	Health promotion in media in 18 provinces of the country.
Section on health of indigenous people in Web page of Health Ministry, PAHO and other institutions (email address).	

Indigenous peoples in **Ecuador**



Estimated population of Indigenous people in Ecuador	
Pacific Coast	
Awa	1.600
Chachi	4.000
Tsachila	2.000
Highlands	
Quichua	3.000.000
Amazonas	
Quichua	60.000
Cofan	800
Siona - Secoya	1.000
Shuar	40.000
Achuar	500
Huaorani	2.000

Source: CONAIE, 2000

El Salvador

1. International Agreements and National Policies.

International Agreements	Legal Frameworks		Technical units responsible of Health of Indigenous People.	
	National Policies Constitution	Health Policies	Government instances /Ministry	Contact Information
Resolution CD37. R5/OPS. Resolution CD40. R6/OPS. International Convention for Elimination of all forms of Racial Discrimination. American Convention of Human Rights	There is no article in the Constitution of the Republic that specifies work with indigenous peoples.	There are no specific policies for the attention of indigenous people.	**Health Ministry.** There is no national policy for the development of indigenous people.	Sandra de Marroquín Tel: 247-7851

Note: El Salvador presented two evaluations made by Health Ministry and by the National Indigenous Coordinator Council of Salvador. In this section we present a combined abstract of both evaluations.

2. Strategic alliances and inter institutional and inter sectorial collaboration networks

Agreements of Indigenous Health Program.	> None
Inter institutional inter sectorial projects of the Indigenous Health Program.	> Strengthening of the Water and Sanitation boards (JAAS) in five indigenous communities: Nahuizalco, Tacaba, Guatajiagua, Cacaotera and Tonacatepeque. > Work plan integrated into the health (traditional and western model) of indigenous people with the Health Ministry in Sonsonete, Santa Ana and Ahuachapan departments > Water and sanitation projects, national coverage, 1996-2001. > Degree studies towards safe maternity carried out in the western zone, 2003.
Multi country projects	None
Inter institutional /inter sector fora.	> National forum on conditions of basic sanitation from the perspective of indigenous people of Cuisnahuat, Izalco and Nahuizalco held in San Salvador city, November 2003. > National Work Group and CTMPI of water Project and sanitation with indigenous communities.
Indigenous organizations that include management of health in their political agendas.	> Coordinating National Indigenous Council of El Salvador (CCNIS).
Networks	Technical Multi sector Committee in support of Indigenous People. The organization model is based on the Coordinating National Indigenous Council of el Salvador (CCNIS) in which different indigenous organizations of the country are integrated.

3. Primary attention of health and interculturality

Policies that promote the incorporation of indigenous perspectives, medicines and therapies in National Health Programs.	None.
Experiences or harmonization of indigenous and conventional health systems.	First meeting for the coordination of the Cosmo vision of indigenous people and the Public Health Ministry and Social Assistance held in Apaneca, Ahuachapán on November 3rd, 2003.
Associations of indigenous therapists.	None.
Training programs and the development of human resources (research and scholarships).	None.

4. Information, analysis, monitoring and management

Information on the demographic, socio economic and epidemiological profile of indigenous people.	Profile of indigenous people of El Salvador, issued in January 2004. Talleres Gráficos UCA.
Information systems, monitoring, and health evaluation of indigenous people. Includes ethnic variable.	There is no specific information system on indigenous people.
Localization maps of indigenous people in the countries as per political division of the country (see annex).	The profile of indigenous people of El Salvador includes maps of geographical localization of indigenous people. *(page. 174)*
Characterization of indigenous people regarding their life and health conditions, social organization and maintenance and restoration of health.	Own efforts of indigenous organizations with the support of PAHO/WHO El Salvador.
Periodic publications on the health of indigenous people.	None
Section on health of indigenous people on the Web Page of the Health Ministry, PAHO or other institutions (email).	PAHO / WHO El Salvador.

Second part

1. **What are the most outstanding achievements in the health care of indigenous people between 1995 and 2004?**

> Visualization of indigenous problems;
> Characterization of indigenous people of El Salvador;
> Recognition of effective use of indigenous knowledge in health care.

2. **What are the priority problems in health care of indigenous people in period 1995-2004?**

> Lack of access to health services
> Lack of access to water and sanitation

3. **What are the aspects to be considered in health insertion of indigenous people as a priority in the processes that the country is promoting in the renewal of Primary Care Strategy and fulfillment of Millennium Goals?**

> Participation of indigenous people in health management.

Third part

Table 1. **Population and indigenous peoples of El Salvador** (population in thousands of inhabitants)

National Population	Indigenous Population (estimate)	%	Peoples
6,757	743	11	3

Table 2. Challenges, factors to be considered, inequities

Challenges

The health strategy and public health should encompass and face structural risk factors and be inserted in the strengths of indigenous people: A holistic vision of the well-being of the individual, family and environment respecting the inter-culturality of indigenous people.

> Factors to be considered

Indigenous populations are scattered over national territory and with more populations in rural western, south and north areas of San Salvador and eastern parts of the country. These areas are of difficult access.

> **Location:** Indigenous populations in El Salvador are dispersed in 11 departments or 78% of departments in the country. The Nahualt-Pipil in Ahuachapán, Santa Ana, Sonsonete, La Libertad, San Salvador, La Paz, and Chalatenango departments; the Lencas in the Usulután, San Miguel and La Unión departments; Cacaopera in Morazán.

> **Ethnic and cultural heterogeneity:** The indigenous population is estimated at 743.314 inhabitants, 11% of national population distributed in three communities Lencas, Nauta-Pipil and Cacaopera. They are present in 11 of the 14 departments of the country.

> **Culturally adequate care:** Basic Health care and preventive programs.

Inequities

> **Poverty:** 38% is qualified as extreme poverty, 61% poverty 0,6% with coverage of basic health needs (National profile of Indigenous People of El Salvador).

> **Illiteracy:** 10-65 years. National average is 21,5% and in indigenous people is 35,24% as per UNICEF and as per PAHO 40,5% (National Profile of Indigenous Population of El Salvador).

> **Unemployment:** Unemployment rate in indigenous population is 24% (PAHO, 2002).

> **Utilities:** 33% of indigenous population has electric Light, 64% uses oil lamp or fire. 91,6% consumes river water or from wells (PAHO, 2002).

> **Infant Mortality:** no data available for indigenous populations.

> **Maternal mortality:** no data available for indigenous populations.

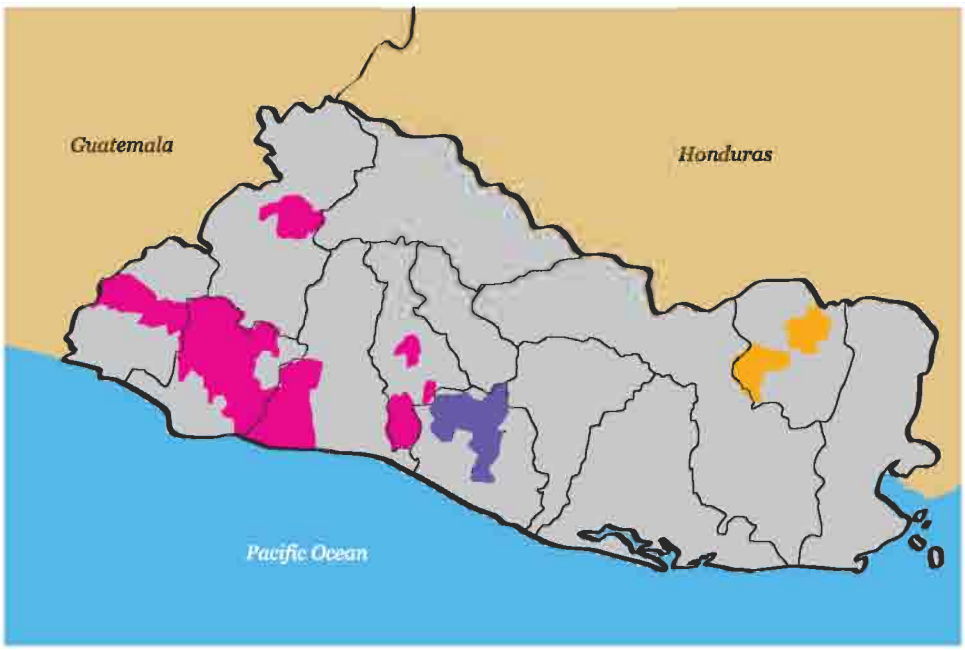
> **Undernourishment:** no data available for indigenous populations.

> **Infectious diseases:** no data available for indigenous populations.

> **Diabetes, obesity alcoholism:** no data available for indigenous populations.

> **Suicide:** no data available for indigenous populations.

Indigenous peoples in **El Salvador**



Comments

That the United Nations System along with indigenous population performs an evaluation of the achievements and limitants within the framework of the Decade of the World's Indigenous People Manage economic resources to follow up inter cultural works of process.

Guatemala

1. International Agreements and National Policies

International Agreements	Legal Frameworks		Technical units responsible of health of indigenous people.	
	Constitution / National Policies	Health Policies	Government Bodies / Ministry	Contact Information
Agreement 169 ILO Resolution CD37.R5 Resolution CD40.R6 Health initiative of indigenous people of Americas, SAPIA.	**Constitution of the Republic,** Guatemala, 1985. **1999.** Health Code, Decree 90-97, *Article 18:* The Health Ministry should define a model for health attention that promotes participation of other sector institutions and organize community initiatives, taking into consideration the national, multi ethnic pluri cultural and multi lingual context. Registry and control of products derived from medicinal plants. Regulation for control of pharmaceutical products and related ones, MSPAS. **2002.** Decentralization Law *Chapter V:* Promotion of citizen participation in the decentralization process and its organization. **2002.** Municipal Code, Articles 18, 20, 21, 36 **2002.** Law of Development Councils. Articles 8, 10 12, 14, 23, 26, **2001.** Law of Social Development. Articles 2, 3,4, 5, 8, 10,14, 16, 24, 25, 26, 32,35.	**Health Policy 2004-2008 II:** To satisfy the health needs of the Guatemalan population by providing health services with quality, warmth, equity and an inter cultural focus.	> Regulation of Programs of Public Health Ministry > National Program of Popular and Traditional Medicine.	> Dr. Edgar Méndez Head of Department Tel. (502)2476-0128 > Dra. Verónica Castellanos Coordinator of Transversal Axis Tel. (502)2471-6046 > Lic Ana María Rodas Coordinator of Program of Traditional and Alternative Popular Medicine Tel. (502)2471-6046 E-mail: anarodascar@yahoo.com

2. Strategic alliances and networks of inter institutional and inter sectorial networks

Agreements of the Program of Indigenous Health	> Agreement on identity and rights of indigenous people. > Socio economic and agrarian situation agreement.
Inter institutional / inter sectorial Projects of Indigenous Health Program.	Research performed by the Meso American Center on Adequate Technology, Agronomy School, Chemical Science and Pharmacy School of the San Carlos University.
Multi country projects.	TCC Mexico-Central America (being negotiated).
Inter institutional / inter sector forums.	GRUTIM, United Nations System.
Indigenous Organizations that include health management in their political agendas	Association of Promoters (ACSMI), Association of Midwives CODECOT, APRUSPLAG, ABSNAV, APROSXIG, APROSARCI, OPCOS, APRUSXAL, APRUSDACI, CAIBA, ASECSA, CPR-IS, CPR-P, APROSAMI, ASSABA, ASSDIC, CIEDEG, IDEI, CCAM,
Networks	Social Concern Ministries of Catholic Church, ASECSA, CDRO, ATI. ASEDE, ADEJU, ADIPO, ASOINDE, CADISOGUA, FUNDEMI, PIES DE OCCIDENTE, ASODESI, ASODESPT, INS, FUNMAYAN

3. Primary health attention and inter culturality

Policies that promote the incorporation of indigenous perspectives, medicines and therapies in the National Health Programs.	> In a document from 2004-2008 entitled Policies and Strategies of Health Ministry of Guatemala, Policy II states " improve health condition of Guatemalan population that places priority on actions of population groups of higher risk".
Harmonization experiences of indigenous and conventional health systems.	> **Research:** Popular and traditional medicine and its articulation in the Network of Official Health Systems, MSPAS, PAHO/WHO, Guatemala. > Proposal and incorporation of traditional and alternative popular medicine in the Reform of Health Sector. > Proposal for the regulation of artisan centers for the preparation of phyto therapeutics > Proposal design to incorporate elements of traditional popular medicine in the standards of first and second level care. > Validation process of the attention standards in first level care. > Preparation of a proposal of Regulation for alternative and complementary medicines > Study on non toxicity, effectiveness of phyto therapeutic products: tincture of guava leaves, tincture of Jacaranda flowers, cough syrup. > Characterization of culturally and acceptable elements to optimize rendering of health services (Phase II-IV). > Strengthening of maternal new born care with the following proposals for the evaluation of the training process addressed to the midwife for the strengthening of strategy of maternal homes and for the strengthening of strategy of culturally accessible and adapted hospitals. > Diagnosis of artisan centers for the preparation of phyto therapeutic products. > Awareness programs addressed to personnel in health centers and traditional therapists. > Diagnosis of Health Directions selected with the participation of users, traditional therapists and health service personnel.
Association of indigenous therapists.	ASECSA, ADEPAC (Alta Verapaz), CONADEP (El Petén), ATI (Totonicapán), CEDRO (Totonicapán, Quetzaltenango) CONAPLEMED (Suchitepequez), Clínica Maxeña (Suchitepequez), Médicos descalzos-Chinique (El Quiché).
Training programs and human resources development (research and scholarships).	> San Carlos National University, Institute of Inter Ethnic Studies, Guatemala. > National Health Instance, NGO. > PIES of Occidente, NGO. > ASECSA. > Rafael Landívar University, Guatemala. > Mariano Gálvez University, Medicine School, Guatemala. > In the direction of Ixil health area, the Training Program for Pharmacy assistants has been included as a component on Traditional Popular Medicine.

4. Information, analysis, monitoring and management

Information on the demographic, socio economic and epidemiologic profile of indigenous people.	> Basic Health indicators in Guatemala, 2001. Public Health and Social Assistance Ministry. > Strategy for poverty reduction, Government of Guatemala Republic, 2001
Information, monitoring, health evaluation systems of indigenous people, which includes the ethnicity variable.	2000 Census performed by the National Statistics Institute –INE- it included the ethnical belonging variable.
Localization maps of indigenous people in the countries as per the political division of the country. (include the map in the attachment).	Map of ethno linguistic ethnicity. *(page. 187)*
Characterization of indigenous people regarding life and health conditions, social organization and maintenance and health restoration.	> Research: Popular Traditional medicine and its articulation to the network of Official Health System, MSPAS, PAHO/WHO, Guatemala. > Eder, Karín; García, Manuela. Model of Mayan Indigenous Medicine in Guatemala. Participative Research. Guatemala 2002. > Villatoro, Elba Marina: Promotion of Indigenous Medicine and Therapies in Primary Health Care in Guatemala. Guatemala 2001. > Gallegos V. Rafael, Moran, Carlos: The role of the midwife in its Socio Cultural Context. Guatemala 1999. > Hernández Barillas, Saúl Enrique: Socio Cultural aspects in the handling of pregnancy by empirical midwifes in Chice Municipe, El Quiché. Guatemala 1979. > Hurtado Paz y Paz, Leonor: Articulation of Official Medicine and Traditional Medicine. WHO/PAHO. Guatemala 1997. > Health Initiative of Indigenous People. Development Division of Health Systems. PAHO/WHO. Washington D.C. 1997. > Research on Traditional Medicine of Guatemala for the Integration in the Primary Care System in Health of the Country. Maya Quiché Area. Totonicapán Guatemala. 1990. > Rossel Enrique: Medicine among Mayas. Thesis, School of Medicine, USAC. Guatemala, 1964. > Villatoro, Elba Marina: Life and work of the Medicinal Healers of El Petén. Guatemala. In Popular Tradition. No. 38. Guatemala 1982. > Villatoro, Elba Marina: Ethno Medicine in Guatemala. Guatemala 1984.
Periodical publication on health of indigenous people.	> National Health Instance, NGO. > San Carlos National University, Institute of Inter Ethnical Studies, Guatemala.
Health section of indigenous people in the Web Page of Health Ministries, PAHO and other institutions (electronic address).	

Second part

1. What are the most relevant achievements in the health care of indigenous people between the 1995 and 2004 period?

> Agreements signed between the Government of the Republic and URNG[42] in the search of a firm and lasting peace, particularly the "Agreement on Socio Economic Aspects and Agrarian Situation" and the "Agreement on Identity and Rights of Indigenous People" recognize the importance of evaluating indigenous and traditional medicine, in the promotion of its study and rescue of conceptions, methods and practices;
> National Program of popular and traditional medicine, 2001;
> Health Policies 2000-2004 with specific policies addressed at the head of the Maya, garifunas and xincas people, with emphasis on women; access to essential medicines and traditional medicine;
> The beginnings of a process for the articulation of traditional popular medicine with state health services, availability and use of medicinal plants;
> Experience in the research of autochthonous medicinal plants which has allowed the preparation of a report and the validation of the use of plants at San Carlos National University, Guatemala and the Public Health Ministry;
> Installation of artisan laboratories for the processing of products derived from medicinal plants;
> Characterization process, strengthening and incorporation of traditional medicine to the rendering of health services through participation of organized groups;
> Training of indigenous women for the strengthening of the systematic use of medicinal plants in the three main health problems of the country (respiratory, digestive and skin diseases);
> Proposal for the regulation of artisan centers for the preparation of phito therapeutics;
> Design of a proposal for the incorporation of elements of traditional popular medicine in the attention standards of the first and second level of care;
> Validation process of the standards of attention in the first level of attention;
> Preparation of proposals of the Regulation for Alternative and Complementary Medicines;
> Study on non toxicity, effectiveness of phyto therapeutic products: tincture of guava leaves, tincture of Jacaranda flowers, cough syrup;
> Characterization of culturally accessible and acceptable elements to optimize the rendering of health services (Phase II-IV);
> Strengthening of maternal new born care with proposals for the evaluation of a training process addressed for midwifes; for the strengthening of strategies of maternal homes and the strengthening of strategies of hospitals culturally accessible and adapted;
> Institutional Inter Program Coordination: National Program of Reproductive Health, National Program of Pharmacy Surveillance and Department of Development of Health Services.

2. What are priority problems in health care of indigenous people in the 1995 2004 period?

> First 10 causes of morbidity: respiratory infections 23,01%; acute diarrheic disease 9,28%; intestinal parasitism 8,46%; anemia 3,93%; pneumonia 4,37%; peptic disease 2,65%; skin diseases 3,66%; urinary tract infections 1,90%; malaria 0,75%; arthritis 0,56%; other causes 41,43% (Annual Book of epidemiologic surveillance 2000, Epidemiology Department,

[42] Unidad Revolucionaria Nacional Guatemalteca.

Public Health and Social Assistance Ministry, Guatemala Republic);

- First 10 causes of mortality: pneumonia 19,95%; acute diarrheic disease, 7,46%; cardiac congestive insufficiency 4,63%; badly defined causes 4,46%; acute infarct of the myocardium 4,06%; cancer 3,06%; undernourishment 3,05%; brain vascular accidents 2,81%; septicemia 2,44%; trauma 2,13% other causes 45,95%. (Annual Memory of epidemiologic surveillance 2000, Epidemiology Department, Public Health and Social Assistance Ministry, Guatemala)

3. What are the aspects to be considered in health insertion of indigenous people as a priority in the process that the country is promoting for the renewal of Primary Care Strategy and fulfillment of the Millennium Development Goals?

- Prepare a national health system including the different models of health attention practiced in the country;
- The participation of indigenous people in the planning, management, implementation and auditing of public health policies;
- Revise and implement legal framework that favors the health of indigenous people;
- The participation of indigenous people in conducting public institutions related to health;
- The social and political recognition of Mayan indigenous medicine;
- The promotion of Mayan Indigenous Medicine;
- The strengthening of traditional therapists and midwives;
- The promotion and organization of traditional therapists and midwives.

Strategic Analysis	
Strengths: particular characteristics of the country that help facilitate actions aimed at improving the health of indigenous people.	**Weaknesses:** negative aspects in the country that make difficult actions aimed at improving the health of indigenous people.
> Legal support; > Peace Agreements: Global Agreement on Human Rights. Agreements on Identity and Rights of Indigenous People, Agreements on Socio economic aspects and Agrarian Situation; > Health Commissions at municipal and departamental levels; > In Guatemala, 25 different cultures exist; > Most of the population is indigenous; > There is growing organization and participation among indigenous people; > Mayan medicine has a health model that cures and works and it is acceptable to most of the population; > Increasing demands of indigenous population to cover their basic needs; > Decentralization of health services will require the participation of indigenous people; > Previous experiences in the articulation of traditional medicine and health services; > Population is aware and accustomed to use traditional medicine.	> There is a hegemonic culture that imposes its ways on health care; > A lack of political will of state authorities in relation to health; > Institutionalized racism and discrimination; > Poor budget for the Health Ministry; > The human development index is lower in indigenous communities.
Opportunities: factors that are in context and that are in favor of improving the health of indigenous people.	**Menaces:** negative factors that affect the implementation of actions aimed at improving the health of indigenous people.
> Decentralization and social development policies; > Social and political movements of indigenous populations; > The revitalizing of Primary Health Care; > Finland Project. Extension of coverage in the second level of care (MSPAS; PAHO/WHO); > Extension of Social Protection in Health (MSPAS PAHO/WHO); > ASDI Project, Comprehensive Health Model-developed and implemented on the basis of rectorship, social participation and local management (MSPAS, PAHO/WHO).	> Lack of political will; > Racism and discrimination; > Lack of large financial investment in health; > Social exclusion.

Third part

Table 1. Population and indigenous peoples of Guatemala (population in thousands of inhabitants)

Population	National Population	Indigenous Population	%	Peoples
More than 40%	11.678	5.004	42,85	23

Source: Basic Health Indicators in Guatemala 2001, Ministry of Public Health and Social Assistance.

Table 2. Challenges, factors to consider and inequities (part 1)

Challenges

Health Strategies and Public Health should understand the structural risk factors and be included in the strengths of indigenous people:

> Integral vision, human being, environment, cosmos; individual, family and community;
> Primary Health care (APS);
> Inter program Inter Sector Coordination.

Factors to be considered

Popular traditional medicine is an integrated medical service of knowledge, practices and human, natural and supernatural resources that offer answers to relieve or solve physical, mental, social and spiritual problems that are experienced by most of the population. For example, the National Program of Popular Traditional and Alternative Medicine of the Public Health and Social Assistance Ministry is one such initiative.

> **Localization:** Indigenous populations are dispersed throughout the country in rural and urban marginal areas and are generally in the population where there is a lower index of human development.

> **Ethnic and cultural Heterogeneity:** 25 ethnic groups in the country and the highest percentage of the population are indigenous.

> **Culturally appropriate care:** Strengthening of maternal new born care with

> **First Level:** proposal for the evaluation of training programs addressed at midwives;

> **Second level:** proposal for strengthening of maternal homes

> **Third level:** third level; proposal for strengthening of culturally accessible and adapted hospital.

A process has been initiated for the articulation of traditional popular medicine with state health services availability and use of medicinal plants.
An additional process has been created for the characterization, strengthening and incorporation of traditional medicine to the rendering of health services through the participation of organized groups.

Table 2. Challenges, factors to consider and inequities (part 2)

Inequities

Direct out-of-the-pocket expenses are 61% of the expenses incurred in families, according to Social Protection in Health, Public Health and Social Assistance Ministry, 2001.
The departments that present the lowest index of human development (0.5) coincide with those of higher indigenous populations, according to the Studies of Human Development, System of United Nations in Guatemala.

> **Poverty:** As per the National Line of Poverty, it was determined that 54.1% of the population faces general poverty conditions and 27.8% suffer from extreme poverty. Source: Report on Human Development 2001. Guatemala: The financing of Human Development. Systems of the United Nations in Guatemala, Guatemala, 2001.

> **Illiteracy:** 29,80% total index in the country from the Basic Health Indicators in Guatemala 2001.

> **Unemployment and sub employment rates:** Inflation rates ended December 2000 and reached 5.1, which is slightly higher than that of 1999 (4.9%). As per reports of Banco de Guatemala, in December 2000 the internannual variation of underlying inflation was 5.0% compared to 8.4% in 1999. Source: ASIES, Economic Evaluation 2000.

> **Utilities:** Some indigenous homes (16.5%) are contributors of social security and allocate 9% of their income to social security quotas and 10.9% of contributors attend to appointments in that institution. 45% of the rural population has coverage extension in the first level of care. Social health protection, 2002, MSPAS, ASDI and PAHO/WHO.

> **Infant mortality :** At national level is 39,77 x 1.000 NV (Basic Health Indicators Guatemala 2001, Public Health and Social Assistance Ministry).

> **Maternal Mortality:** Rates of maternal mortality at a national level are 153,03 RMM x 100.000 born alive. Rates of Maternal Mortality in indigenous women are 211 RMM x 100.000 born alive. (Final Report of Final Base Line of Maternal Mortality for year 2000, Public Health and Social Assistance Ministry).

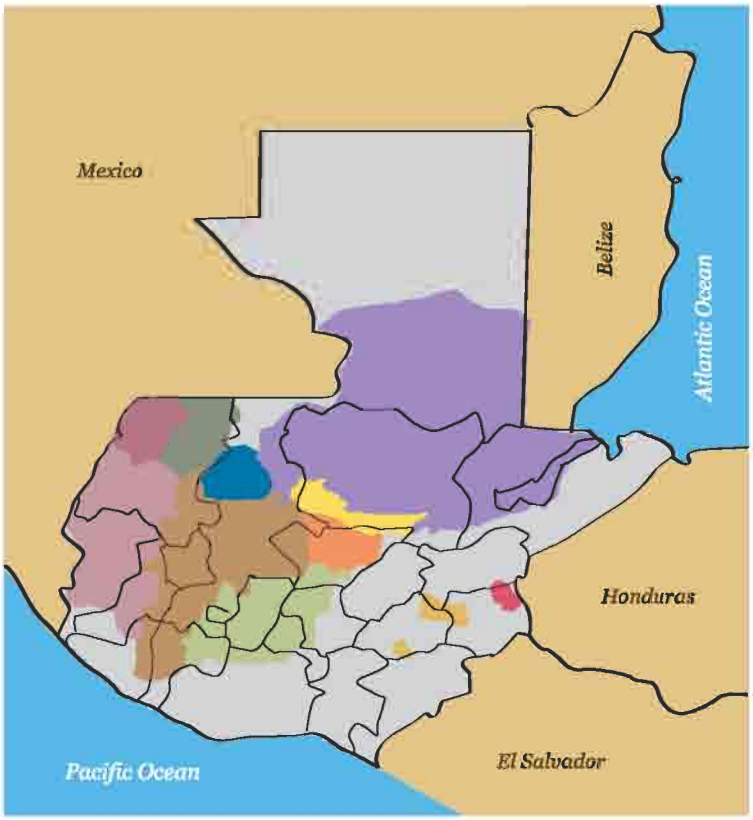
> **Undernourishment:** chronic undernourishment is 67.8% among indigenous people and 36.7 among non indigenous people (PAHO, 1999).

> **Infectious diseases:** Malaria 84,7 x 10.000 inhabitants; dengue 4,04 x 10.000 inhabitants; pneumonia 209,08 x 10.000 inhabitants; diarrhea 43,51 x 100.000 inhabitants; cholera 1,02 x 100.000 inhabitants; basic health indicators in Guatemala 2001, MSPAS. TB 17,64 x 100.000 inhabitants; Epidemiologic Bulletin 2000, MSPAS.

> **Diabetes, obesity, alcoholism:** Information to be provided by MSPAS.

> **Suicide:** Diseases due to suicide at national level 412. Basic Health Indicators in Guatemala 2001.

Indigenous peoples in **Guatemala**



- Q´eqchi
- Poqomchi
- Achi
- Kaqchikel
- Kl´che
- Ixil
- C´anjob´al
- Chuj
- Tektiteko
- Poqomam
- Ch´ortí

Comments

To complete the Evaluation Instrument of the International Decade of Indigenous People of the World, Guatemala Chapter, information was obtained from the Public Health and Social Assistance Ministry (MSPAS), National Program of Popular Traditional and Alternative Medicine (PMPTA), Association of Community Health Services (ASECSA), Dr. Rafael Haeussler, independent advisor; Dr. Carlos Lix, independent advisor, Data Base of PAHO/WHO Guatemala Representation; Academia of Mayan Languages of Guatemala (ALMG).

Honduras

1. International Agreements and National policies.

International Agreements	Legal Framework		Technical Units responsible for the Health of Indigenous Peoples	
	Constitution/ National Policies	Health Policies	Government Level/ Ministry	Contact Information
Agreement 169. International Labor Organization (ILO). Resolution CD37. R5/PAHO. Resolution CD40. R6/PAHO.		Health Policy 2002-2006, states "Improve the access to health services, putting attention to and reducing inequities of any kind, (gender, indigenous peoples, social status, place of residence, occupation, political or religious belief)".	> National Assistance Program to Ethnic Groups. > Network Services Branch, Ministry of Public Health. > PRONEEAA > INA > PAPIN (Ministry of Justice). > Ministry of Agriculture and Livestock (SAG). > Ministry of Labor. > Fiscalía de las Etnias y Cultural Heritage Public Ministry. > Liaison Commission for Indigenous peoples. > Presidency of the Republic. > SOPTRAVI. > Our Roots FHIS.	> Dr. Gerardo Medina Tel. (504)236-7995 Ing. Guillermo Díaz

Note: The information contained here is a summary of a broader document prepared by the country.
This document is kept in the archives of the Health Program for Indigenous Peoples of the Americas at PAHO headquarters.

2. Strategic Associations and interinstitutional / intersectorial collaboration networks

Indigenous Peoples Health Program Agreement	Commitment Acts Ministry of Health and Confederation of Honduran Autochthonous Peoples (CONPAH)
Interinstitutional/ intersectorial Projects	> Project for water supply, latrines and housing improvement for Lenca people at Intibucá departments (San Francisco Opalaca and others), Francisco Morazán (Tolupanes tribes, from Mountain Flor) and Lempira (San Francisco de Lempira, Gualsince and others). Participant Institutions: Catholic Relief Service (CRS) and Doctors with no borders. > Formation of Indigenous nursing assistants (Lenca, Chortí, Tolupan,Tawahka, Misquito, Garífuna, Pesch). Participant Institutions: Spanish Cooperation, Swedish Cooperation (ASDI), indigenous-based organizations, > Ministry of Health, PAHO. Building of health centers. Participant institutions: Honduran Social Investment Fund (FHIS) and Ministry of Health. > Elimination and control of Triatomins in indigenous peoples Tolupán, Chortí, Lenca. Integral treatment for the control of Chagas disease, mainly in the municipalities of San de Sierra, San Francisco de Opalaca, Mountain Flor, Copan Ruinas and tolupanes tribes of Yoro Department. Participant Institutions: Ministry of Health, Swedish cooperation ASDI, and Doctors with no borders. > Emergency Food Project 1996. Participant Institutions: Ministry of health, World Food Program, Ministry of Agriculture and livestock. > HIV/ AIDS Project. Participant Institutions: Ministry of Health > Malaria Project. Participant Institutions: Ministry of Health, Spanish Cooperation and Swedish Cooperation (ASDI). > Project of action and demonstration of Sustainable Alternatives for the control of Malaria vector without the use of DDT or any other pesticides. Participant Institutions: Ministry of Health PAHO/WHO, GEF.
Multi-countries Projects.	> TCC, Honduras – Nicaragua, in miskita population. Assistance to disable divers due to the syndrome of medullar decompression and establishment of RBC in miskita zone. Participant Institutions: Ministry of Health, PAHO/WHO. > Honduras-Nicaragua Bi-national/Bilateral Project on oral health for Indigenous peoples.
Interinstitutional / intersectorial Forums.	> National Working Group of National Water and Basic Sanitation for the population of Tawahka, La Mosquitia. > I National Forum on Inter-culture and Health. Attention to black and indigenous peoples with institutional personnel from regions and areas having indigenous presence. > Formation of the personnel for the intercultural attention of the population of the department Gracias a Dios. > I Forum on human rights of disabled people and indigenous peoples in Honduran Moskitia
Indigenous organizations which include health care in their political agendas.	All indigenous federations, agglutinated in the Confederation of Honduran Autochthonous Peoples (CONPAH).
Networks	There is no network of indigenous health.

3. Primary health care and cultural diversity

Policies enhancing the incorporation of indigenous perspective, medicines and therapies in National Health Programs.	In the governmental policy and plan addressed to the public health sector, no medicines or indigenous therapies have been incorporated since they count with a generalized health system and not a differentiated one for the indigenous population.
Experiences of the harmonization between the indigenous health systems and conventional ones.	Some religious organizations, especially the protestants, consider profane the traditional practices of indigenous health systems; in addition of this, foreign cultures do not respect such practices and aged people avoid making their ceremonies; so as time goes by, this culture is being lost.
Associations of indigenous therapists	Do not exist, although in the cosmic vision of every town, there are traditional therapists networks which are not recognized by the government/State, like for instance the SIKA KAKAIRA (The Botanist), SUKIA (Spiritual guide), SUAYA KAKAIRA (person that interprets the involuntary movements of the body), in the Miskitos town.
Human resources formation and development Programs (research and scholarships).	Scholarships offered by the Cuban government have favored about 100 indigenous and afro descendants to study medicine in Cuba. Others have been benefited with scholarships in Georgetown University and the United States.

4. Information, analysis, monitoring and management

Information about the demographic, socioeconomic and epidemiologic profile of the indigenous peoples.	There is no differentiated information system that receives information on indigenous health
Information, monitoring, evaluation systems of the health of indigenous peoples. It includes the ethnic variable.	It does not exist
Localization maps of indigenous peoples inside the countries according to the country's political division. (Include the map in annex).	Annexed. *(page. 200)*
Characterization of indigenous peoples in respect to their living and health conditions, social organizations as well as maintenance and recuperation of their health.	In process.
Periodical publications about the health conditions of indigenous people	It does not exist
Section about the health conditions of indigenous peoples in the electronic page of the Ministries of Health, PAHO or other institutions (e-mail address).	It does not exist

Second part

1. What are the most relevant achievements concerning health care of indigenous peoples during the period 1995-2004?

The work done with the black and indigenous peoples, as a process of dialogue, negotiation and convergence, gave birth in 1994 to the first mass mobilization carried out in July of same year, in which Lencas, Tawahkas, Chortí, Tolupan, Pech, Misquitos, English-speaking blacks and Garifunas participated. The issues put on the negotiation table to be discussed with the government of the Republic, may be grouped into four basic aspects:

Creation, broadening and strengthening of public health services, including construction, widening of infrastructure works, equipment for service providers, medicine supplies, training of human resources and appointment to personal (general medicine doctors, nursing assistants, professional nurses, community development promoters and lab technicians).

- The environmental sanitation was raised basically by the demand of installing water supply systems and latrines
- Development of local models and/or traditional health systems under the concept of organization and installment of community health houses as well as the incorporation of traditional medicine into health services
- Social control on health services management in respect to quality and warm attention, building of strategies and spaces for regulations

The effort made has been historical either for the black and indigenous movement or for the Ministry of Health because it is an emerging experience that requires a systematic and disciplined involvement as well as a political will.

2. What are the priority issues regarding health care of indigenous peoples during the period 1995-2004?

- The need to create a national assistance policy for indigenous peoples.
- The need to create a permanent forum for the promotion of indigenous people's health with an intercultural approach.
- Creation of a national subsystem to monitor indigenous health.
- A national indigenous census.
- To deepen into the socio-cultural studies of each ethnic group
- To Design and promote models for intercultural assistance to black and indigenous peoples.
- Traditional medicine studies
- Training of human resources for the work with the peoples
- Evaluation of the impact of the work done by the National Program of Ethnic Groups.
- Organization and establishment of public health options like the indigenous health houses.
- Re-establishment of the relations between the peoples and technical units of the Ministry of Health in light of a true political will, favorable to negotiation and agreement.

3. What are the aspects to be inserted into the health of indigenous peoples as part of the priorities in the processes the country is promoting for the renewal of the Primary Health Care Strategy and the fulfillment of the Millennium Goals?

- Training of the human resource who works with the health subject giving priority to the persons who come from those peoples.
- Access to the indigenous population health services with equity, quickness and efficiency .
- Respect for cultural identity.
- Inter-culture as the core in all indigenous health services

Strategic analysis	
Strengths: particular characteristics of the country which would facilitate the actions towards the improvement of the indigenous people health.	**Weaknesses:** inner negative aspects of the country which would difficult the actions towards the improvement of the indigenous people health.
> Existence of a national indigenous health care program > Availability of competent technical resource at community level. > Indigenous federations organized into a unique confederation of autochthonous peoples	> There are no national policies of health for indigenous peoples. > There is no situational analysis of indigenous peoples. > Representative organizations of black and indigenous peoples have no access to funding for the direct implementation of health programs. > The reform at the Ministry of Health level which transformed the Department of Assistance to Ethnic Groups into a program, was not negotiated. Thus, this brought about the retreat of the peoples organizations from the national health process. > The program coordinator does not have the support of the Ministry of Health authorities > The ethnic Group program does not have a budget which meets the needs and demands of the peoples. > The organizations of the peoples do not have their own budget for the development of health actions. > The peoples show distrust to the work of the Ministry of Health which becomes an obstacle for the incorporation of traditional models into the intercultural health assistance.
Opportunities: factors that exist in the context and it is believed they would act in favor of the actions to be aimed at improving the health of indigenous peoples.	**Threats:** negative factors that may affect the implementation of actions aimed at improving the health of indigenous peoples.
> Americas Indigenous Peoples Health Program of PAHO/WHO. > Existence of a focal centre for indigenous health in PAHO/WHO-Honduras, committed to the health of indigenous peoples > Support to the universities UNAH and UPN.	> Lack of political will in the attention to the health demands of indigenous peoples. > Division among indigenous organizations generated by the government on duty, like it is the case of programs PAPIN, from the Ministry of Justice and the program Our Roots, from the Honduran Fund of world Bank Social Investment (FHIS).

Third part

Table 1. Population and indigenous peoples of Honduras

National Population	Indigenous population (estimate)	%	Peoples
6.194.926	743.391	12	9

Table 2. Challenges, factors to be considered and inequities (part 1)

Challenges

Health strategies and public health must understand and deal with structural risk factors, and insert them into the strengths of indigenous peoples.

Factors to be considered

> **Localization:** *Honduran indigenous peoples and ethnic groups are spread throughout the national territory.* In general, they are located in remote zones, some of which not only have a border with neighbor countries but also have a border determined by the administrative and political division of the country. For instance, Miskitos and Chortís have a common border with Nicaragua and Guatemala respectively, and in the west, Lencas and Chortís live in the territories which border on Guatemala and El Salvador.
Regarding the localization of indigenous peoples, in terms of geographical regions, Garifuna, English-speaking blacks, Miskitos, Tawahkas and most of Tolupanes communities are located in the Atlantic coast, and some Tolupanes communities, Lencas of Francisco Morazán, Pech and Nahualt are located in the central region, in the Department of Olancho. Approximately, 50 % of these peoples live in forest conifer regions, 30 % in coastal zones and 20 % in ecological reserves such as Tawahca forest Plátano River.

Cultural and ethnic heterogeneity:

Honduran indigenous population is distributed into 9 peoples culturally differentiated: Lencas (binational peoples HOND-ELS), Chortís (binational peoples GUT-HON), Tolupanes, Tawahkas, Garífulnas, English-speaking blacks, Pech, Nahualt and Miskito (binational peoples NIC-HON). These peoples are the foundations of the multiethnic, pluricultural and multilingual profile of Honduran population.

Inequities

> **Culturally appropriate care:** the access to public health care already low in the rural areas, becomes worse in the zones of settlements of indigenous peoples. In general, indigenous communities are spread out and can be located in isolated zones, of difficult access and with borders.

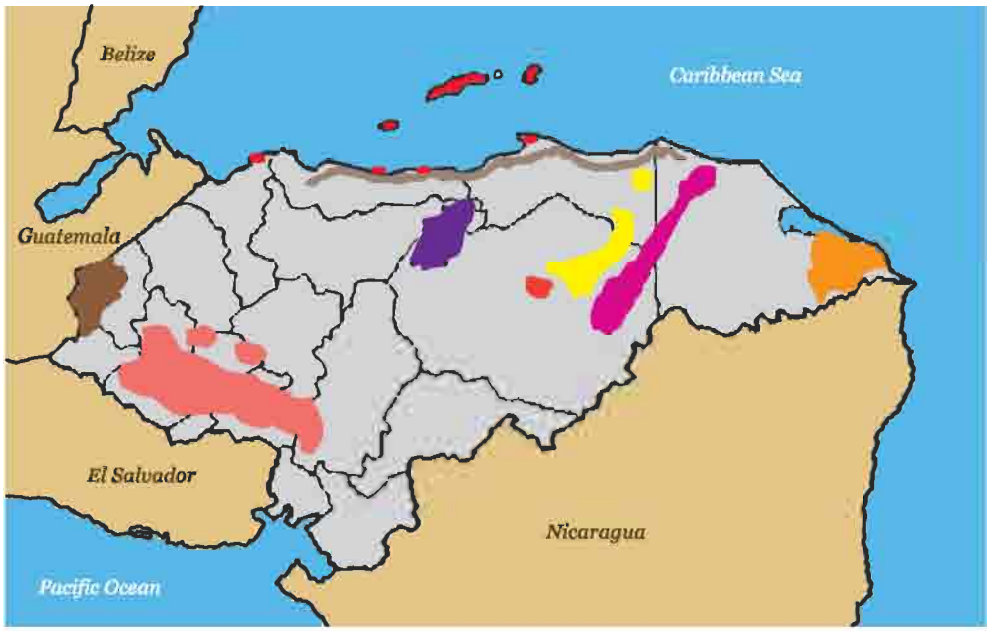
> **Poverty:** The monthly standard income per indigenous family is US$40,00. The monthly standard income at a national scale is US$82,00.

Table 2. Challenges, factors to be considered and inequities (part 2)

> **Maternal mortality:** the maternal mortality rate fluctuates between 190 and 255 per 100 thousand born alive in the departments with indigenous population. The national rate is 147.

> **Infectious diseases:** A study made between 2000–2001 on 160 women from garífuna people at reproductive age found out 1% seropositive with syphilis, 34% with hepatitis B, 13% positive with HIV and 9% positive with other sexually-transmitted diseases. Regions 6, 7 and 8, settlement zones of Miskito, Pech, Tawahca and Tolupán peoples, accumulate 64% of malaria cases from all over the country.

Indigenous peoples in **Honduras**



- Chortis
- Garifunas
- Lencas
- Tawakas o Sumus
- Pech o Payas
- Tolupanes o Xicaques
- Miskitos
- Black people, English speakers
- Nahoas

Mexico

1. International Agreements and National policies

International Agreements	Legal Framework		Technical Units responsible for the health of indigenous Peoples	
	Constitution/ National Policies	Health Policies	Government Level/ Ministry	Contact Information
Agreement 169 ILO [41] Resolution CD37.R5 Resolution CD40.R6[42]	**The Constitution** recognizes and guarantees the right of indigenous peoples and communities to free determination, and, in consequence, to autonomy so as to ensure effective access to health services by means of widening the national system coverage, and using appropriately the traditional medicine ***Article 2.*** The Mexican nation has a pluricultural composition, originally based on its indigenous peoples. **Act 21/05/2003.** National Commission for the Development of Indigenous Peoples Act. **Ministry of Health Internal Regulations. Article 25 Section VII.** It proposes the design and development of new assistance models in accordance with the needs and cultural features of the population. **Section XVII.** To address actions to the training and intercultural awareness of the national health system personnel.	**2004.** Peoples Insurance for Indigenous Peoples, focused to meet the health needs of indigenous peoples. Traditional medicine projects and intercultural health services Elaboration of draft policies for indigenous people's health care. Process of intercultural training to personnel studying in medicine and nursing schools.	>National Commission for Indigenous Peoples Development, adjoint to the presidency of the Republic >Vice-management of Strategic Programs in indigenous rural areas, Health Services Management Branch. National Commission for Health Social Protection, Ministry of Health. >Traditional Medicine and Intercultural Development Branch, Health Planning and Development Branch, Undersecretary Office of Innovation and Quality. Ministry of Health	>Lic. Carlos Zolla E-mail: czolla@att.net.x >Dr. Gonzalo Solis Cervantes Los Pinos Mexico, Federal District Tel. (52-55)5651-3199 E-mail: leogonsol@hotmail.com >Lic. Luciano Rangel Castillejos Deputy Director E-mail: lcastillejos@salud.gob.mx >Dr. José A. Almaguer González Av. J. M. Vasconcelos 221, 5to. Piso, Col. San Miguel Chapultepec 11850 México D.F. Tel. (52-55)5211- 7747 E-mail: medicinatradicional@salud.gob.mx.

[41] The Agreement 169 of ILO (1989) has been ratified by the following countries: Argentina, Bolivia, Brazil, Colombia, Costa Rica, Dominica, Ecuador, Guatemala, Honduras, Mexico, Paraguay, Peru, Venezuela (ILO, 2004: http://www.ilo.org/ilolex/spanish/convdisp1.htm)

[42] The 35 Member States of PAHO expressed their commitment to prioritize the assistance to the indigenous peoples of the Americas by signing the Resolutions CD37.R5 (1993) and CD40.R6 (1997).

2. Strategic Associations and Interinstitutional / intersectorial collaboration networks

Indigenous Peoples Health Program Agreement	No
Interinstitutional/ intersectorial Projects of the Indigenous Peoples Health Program	National: Health and Nourishment for Indigenous Peoples. Interinstitutional: Health, Water and Drainage in order to reduce the presence of trachoma in San Juan, Cancun, Chiapas. > Cultural Diversity Campaigns (CONACULTA, CONAFE, CDI, CONAPO, SSA). > Linguistic Policies Directives (INALI, SSA, CONAFE, CONACULTA, CDI).
Multi-countries Projects.	Joint Project México/Centro America/PAHO for intercultural health care in the indigenous rural communities of México and Central America
Interinstitutional / intersectorial Fora.	National Working Group in the Project: Water, Health and Sanitation to reduce the presence of trachoma in San Juan Cancun, Chiapas.
Indigenous organizations which include health care in their political agendas.	No
Networks	No

3. Primary health care and cultural diversity

Policies enhancing the incorporation of indigenous perspective, medicines and therapies in National Health Programs.	Health policies for indigenous peoples establish the adjusting of health services to sociocultural features of the population, with full respect to health care traditional practices. The Internal Regulations of the Public Health Secretariat were modified in order to establish intercultural training at a federal level and to propose health care models considering the cultural features of the population. (Art. 25) *(Art. 25)*
Experiences of the harmonization between the indigenous health systems and conventional ones.	There have been established mechanisms of continuous training to health personnel assisting indigenous people, emphasizing in the intercultural relations. People are trained on traditional medicine so that it can be recognized as a valid health system in indigenous regions. Traditional medicine doctors enter into the Honorific Advising Council of Traditional Medicine and Intercultural Development Branch.
Associations of indigenous therapists	The work is done with indigenous organizations from Guanajuato, San Luis Potosí, Puebla, Oaxaca andMichoacán States.
Human Resources formation and development Programs (research and scholarships).	There have been established three universities which focus on the intercultural relations, for indigenous peoples.

4. Information, analysis, monitoring and management

Information about the demographic, socioeconomic and epidemiologic profile of the indigenous peoples.	http://www.equidad.df.gob.mx/indigenas/index.html
Information, monitoring, evaluation systems of the health of indigenous peoples. It includes the ethnic variable.	Health information national system, led by the Information Branch of SSA, is making a lot of efforts to incorporate the variable of ethnic pertinence http://www.salud.gob.mx/unidades/ dgied/sinais/sinais.php
Localization maps of indigenous peoples inside the countries according to the country's political division. (Include the map in annex).	There are a series of national and regional maps where the location of the diverse indigenous peoples is shown. *(page. 212)* http://www.edomexico.gob.mx/sedesem/Mapa%20Pueblos.html http://www.equidad.df.gob.mx/boletines/detalleBoletines.html?id_boletin=21
Characterization of indigenous peoples in respect to their living and health conditions, social organizations as well as maintenance and recuperation of their health.	There are a series of publications in this respect, such as: Socioeconomic indicators of Mexican indigenous peoples, 2002.
Periodical publications about the health conditions of indigenous peoples	No
Section about the health conditions of indigenous peoples in the website of the Ministries of Health, PAHO or other institutions (e-mail address).	The Ministry of Public Health of Mexico, through: http://www.salud.gob.mx/index_anterior.html (Traditional Medicine) and the action program: Health and Nourishment of Indigenous People http://www.ciesas.edu.mx/bibdf/ http://www.gomaya.com/unmasking_sp/resources1.html

Second part

1. **What are the most relevant achievements concerning health care of the indigenous peoples during the period 1995-2004?**

> The acknowledgement of traditional medicine in the Ministry of Public Health and the creation of the Intercultural Development and Traditional Medicine Branch, located inside the Health Planning and Development Branch.
> A strengthening Program which includes the proposal of a chapter for the Health General Act and the regulations for the relationship between public health personnel and traditional medicine practitioners
> The acknowledgement of traditional medicine as a complete and valid system for health care.
> Intercultural Awareness Program.
> The definition of quality evaluation indicators from the indigenous perspective.

2. **What are the priority issues regarding health care of indigenous peoples during the period 1995-2004?**

> Social exclusion, as a conditioner for diseases.
> Population settled in small and remote locations.
> Difficult access to public health services (preventive and curative).
> Spaces/centers of health care, equipment and medicine supplies, designed from the urban vision of health services, without the incorporation of elements of the local culture.
> Cultural barriers of the system, spaces, suppliers and users. Experiences of "mistreatment" and unsatisfaction.
> Adverse events caused by communication problems which are derived from language barriers and cosmovision diversity in respect to health, disease and multiple daily events.
> Distrust towards public health services, reason why they prefer health care from their own people in the community, who, are in many cases not competent enough to detect medical risks and complications.
> Confrontation of the indigenous peoples with the urban culture.
> Devalued and de-empowered user.

3. **What are the aspects to be inserted into the health of indigenous peoples as part of the priorities in the processes the country is promoting for the renewal of the Primary Health Care Strategy and the fulfillment of Millennium Goals?**

Strategic analysis	
Strengths: particular characteristics of the country which would facilitate the actions towards the improvement of the health of the indigenous people.	**Weaknesses:** inner negative aspects of the country which would difficult the actions towards the improvement of the health of the indigenous peoples.
> A strong social and Interinstitutional consensus in the promotion of the rights of indigenous peoples > Legal framework which, in the case of public health, promotes the acknowledgement of diversity, traditional medicine and an institutional synergy in favor of the promotion of human rights and gender equity, with emphasis in the indigenous population.	> Budgetary restrictions, population spread out. > Different cultural and communication codes between the supplier and the user of health services.
Opportunities: factors that exist in the context and it is believed they would act in favor of the actions aimed at improving the health of indigenous peoples.	**Threats:** negative factors that may affect the implementation of actions aimed at improving the health of indigenous peoples.
> Consolidation of the Intercultural Development and Traditional Medicine Branch. > Decentralization of health services, possibility for a greater autonomy on service management.	Unemployment, migration and social exclusion.

Third part

Table 1. Population and Indigenous peoples of Mexico

National Population	Indigenous Population (estimate)	%	Peoples
105 millions	12.4 millions	12%	62

Table 2. Challenges, factors to be considered and inequities (part 1)

Challenges

Health strategies and public health must understand and deal with structural risk factors, and insert themselves into the strengths of indigenous peoples.

Factors to be considered

> **Localization.** Mexican indigenous peoples are spread out all over the territory, most of them concentrated in the south. There is a trend to migration, which has concentrated indigenous peoples in urban areas or even abroad (United States and Canada)

> **Cultural and ethnic heterogeneity.** In Mexico, there are at least 62 indigenous languages with 30 dialectical variants. One fourth of indigenous people speak Náhualt, followed by Maya, Otomí, Tzeltal, Tzotzil, among others. 17 languages have every time less and less speakers and reproduction problems because they have less than 500 HLI.

> **Culturally appropriate attention.** The reform process of the legal framework is initiated. The intercultural training for public health personnel students and for the service personnel is being promoted in schools, as well as amendment proposals for different ordinances of the Ministry of Health, such as: General Public Health Act., Master Plan of Physical Infrastructure, Inner regulations.

Inequities

The human development index; rate of social exclusion, and measurement of poverty show the social, economic and opportunity differences existing in Mexico. They make a diverse, heterogeneous country, with concentration of wealth in the superior quintile and with excluded sectors of the population. The poorest states are characterized by being in the south and having the greatest concentration of rural and indigenous population, as well as diseases considered to be an epidemiological accumulation, such as trachoma.

> **Poverty:** The Mexican states which proportionally concentrate a greater amount of indigenous population are: Yucatan (60%), Oaxaca (49%), Quintana Roo (40%) and Chiapas (29%), all of them located in the south of the country. Considering absolute numbers, Oaxaca state has a 1,67 million of indigenous peoples, followed by Chiapas with 1,14 millions and Vera Cruz with 1,01 millions. According to the rates of social exclusion, 487 municipalities, where more than 70% of their population is conformed by indigenous people, who are considered in a high and a very high social exclusion[46]. This situation explains the relationship between poverty and indigenous peoples.

> **Illiteracy:** The social, economic, educational and health indicators show the enormous differences between the indigenous population when they are compared to national standards, for instance, the illiteracy rate of indigenous peoples gets up to 44% while the national rate is 10%4.[47]

> **Infant mortality:** Infant mortality in Mexico was calculated for 2003 in 20,5 out of 1000 born alive. The trend has been, in recent years, in continuous decrease. Infant mortality of indigenous peoples is 48,3 out of 1000 born alive. It doubles the national standards.

> **Maternal mortality:** In 2002, the country's maternal mortality was estimated in 6.9 of a hundred thousand born alive4, being the gap among states very big, like Colima where maternal mortality rate was estimated in 18,9 while in Oaxaca was 103,1, that is 5,5 times higher. The risk of dying at pregnancy, labor and puerperium is three times higher for an indigenous woman. In Chiapas only 21% of labors are assisted in health care institutions.

> **Malnutrition:** The prevalence of infant malnutrition is 58,3%, the iron deficiency in pregnant women is 60%.

Table 2. Challenges, factors to be considered and inequities (part 2)

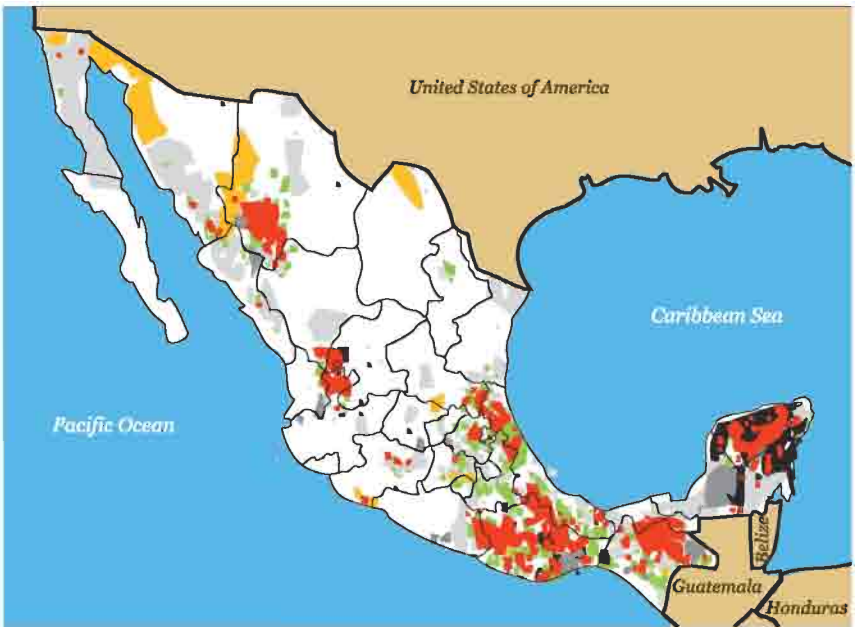
> **Infectious Diseases:** Infectious diseases continue to be the priorities in these populations, where morbi mortality caused by non-transmissible diseases like diabetes and circulatory problems

> **Diabetes, obesity, alcoholism:** Among the emerging problems of the indigenous population, Diabetes is seen, but in particular alcoholism, which is considered a health problem and continues causing health havoc to the health of indigenous peoples.

> **Suicide:** cases of suicides are increasing in adolescents.

[46] National Program of Indigenous Peoples (2001-2006). http://indigenas.presidencia.gob.mx
[47] INEGI 1995 in National Program of Indigenous Peoples (2001-2006). http://indigenas.presidencia.gob.mx
[48] General Information Directory, Secretary of Health, México. 2004

Indigenous peoples in **Mexico**



LOCATIONS

- 40% - 69%
- 70% or more

MUNICIPALITIES

- Less than 5.000 Indigenous people
- Less than 40% of the total population and more than 5.000 indigenous people
- 40% - 69% of Indigenous population
- 70% or more of Indigenous population

Nicaragua

1. International Agreements and National policies. (part 1)

International Agreements	Legal Framework		Technical Units responsible for the health of indigenous Peoples	
	Constitution/ National Policies	Health Policies	Government Bodies/ Ministry	Contact Information
Declaration of the Decade of the United Nations Agreement 169 of ILO has not been ratified The Government is signatory of the Durban Agreements. Resolution CD 37 R5. Resolution CD40 R6.	**Political Constitution.** Article 5, Title 1. Fundamental Principles, clause 3. Article. 91 **Act 21.** Act of Municipalities, Chapter 1, **Art. 63.** Organizations of municipal councils with their respective laws. ***Art. 67.*** Respect for communities and cultures of autochthonous lands ***Art 69.*** Chapter 2. Certification of Management of autochthonous communities. ***Act 28.*** By-law of Autonomy (1987) and its regulations (2003). Chapter 2. ***Act 162.*** Chapter 6, Art. 90. Official Use of languages (1996). ***Act 445***. About the community property regime of indigenous peoples and ethnical communities of the autochthonous regions of the Atlantic coast of Nicaragua and the Bocay, Coco, Indio and Maíz rivers. ***Act 290 of (1998).*** Organization, Capacity, and Procedures of the Executive Power. Art 6. Harmonic performance with autochthonous regional governments. ***Act 292.*** Use of therapeutical plants.	**National Health Policy 2004-2015.** Policy 7. Implementation of innovative health strategies in the autonomous regions of the Atlantic Coast and border municipalities National Health Plan Objective 7. Better health care services in the autonomous regions and its border municipalities	> *Presidency* Advisor of ethnical affairs > *National Assembly* President of the Commission of Ethnical Affairs. Secretariat of Indigenous Parliament of America > President of the Commission of Health Special Law Office of Indigenous peoples and Ethnical Communities > Autonomous Regional council RAAN > President of Health Commission RAAN > Director of Health Secretariat RAAN > Health Advisor of RAAN > Director of SILAIS > Autonomous Regional Council RAAS > President of Health Commission RAAS: > Director of SILAIS RAAS	> Dr. Carlos Hurtado 22289261, 2289287 churtado@presidencia.gob.ni > Delegate Leonel Pantin 2222380, 2225810 indigena@asamblea.gob.ni > Dr. Guillermo Montenegro, 2224960 > Rev. Norman Bent, 2666597, 2668531 > Juan González, 282 2235 > Maria Elena Guerrero, 8448970 > Ned Smith, 2822363 > Eddie Mc Donald, 0282 2235 > Reynaldo Hernández, 8517074 reyhernan@hotmail.com > Reyfield Hodgson, 2227171 08222705 rayfield@ibw.com.ni, > Tatiana Guerrero, 0822-0011 tatianaguerrero@yahoo.es Dr. Donald Jarquín, 8222341 > Dr. José Antonio Alvarado jalvarado@minsa.gob.ni

Ministerial Resolution 7489 of 1989. Creation of the Center of Natural Medicine in Estelí.

Decree 3367. Acknowledgement of headquarters of Indigenous Parliament of the Americas

The General Act of Health 292 and its regulations. Arts 7 (Model of Care), 19 (decentralization). Regulations Arts 60 (Model of Care), 63 (funding sources).

Other laws in favor: Fishing Act, Act 217 (Environment and natural resources), Act 337 disasters, Education Act, Act of citizen participation

Act of Traditional Medicine and Alternative Therapies. Now in process of approval at the National Assembly.

Ministry of Health
> Minister of Health
> Vice Minister of Health
> Technical Commission of Ethnicity

Durban Commission
> Officer in charge of follow-up agreements
> Focal Team of healthy indigenous schools, Integral child care.
> Focal point healthy indigenous environments.
> Rehabilitation. Disability Miskitos divers.
> Direction of Pharmacy, Component of traditional medicine.
> Program of teeth health.
> Project PROSILAIS.

Director SILAIS Nueva Segovia
Director SILAIS Madriz
Director SILAIS Matagalpa
Director SILAIS Jinotega
Director SILAIS Chinandega
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> Dr. Dagoberto Bermúdez

> Dr. Roger Montes, 07222331

> Dr. Jaime Castro, 06123500

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1. Acuerdos internacionales y políticas nacionales (parte 2)

International Agreements	Legal Framework		Technical Units responsible for the health of Indigenous Peoples	
	Constitution/ National Policies	Health Policies	Government Level/ Ministry	Contact Information
				> Dr. María Antonia Tiberino 3412015 silaischi@minsa.gob.ni > Dr. Miguel Valencia, 03116451 silaisleon@yahoo.com > Dr. César Flores, 03115082 > Dr. Iván Alemán > Ms. Mercedes Calderón 05222255, 05224532 > Dr. Silivo Martínez, 04534379 s.riv@minsa.gob.ni

Nicaragua held Sub-national workshops in order to complete the evaluations. The Nicaraguan representative of PAHO published a document about the national evaluation.

2. Strategic Associations and interinstitutional / intersectorial collaboration networks (part 1)

Health Program Agreement for Indigenous Peoples	> Agreements between PAHO/WHO and the Indigenous Parliament of America (from 1996-2007). > Agreements in RAAN: Agreements with divers' trade-unions (in negotiation). > Institutional and labor collective and normative Agreement between maritime employers and employees > Agreement of territorial demarcation > Agreements in RAAS: Agreements of Regional Council with FISE and PRODEC. > Agreements of APRODIN with MINSA (2004-2006), with CEDAPRODE and with NICAAMBIENTAL. > greements of IMTRADEC URACCAN with Mayor's offices, INATEC, CRAAN, FADCANIC, MECD, Supreme Court of Justice of Bilwi, procurator's Office of Human Rights and Indigenous Parliament of America.
Interinstitucional/ intersectorial Projects	**RAAN:** > Austrian Cooperation for Development (OED): Project of the construction of autonomic health models Horizonte 3000 Series of stages, diagnosis, plan, and implementation. > AMICA with the World Bank: Revolving funds for artisan fishers. > AMICA with USAID/DANIDA/CBA Alternative Ecotourism. > Projects of formation in human rights, violence, leadership, AIDS, etc with funds of Swedish Cooperation and KEPA Finland. > Protection of the environment with MARENA. **RAAS:** > Project PROSILAIS (ASDI OPS UNICEF). > Coastal campaign against AIDS > Projects of Christian Medical Action. > Projects MINSA and universities. **APRODIN** > Project on land care, reforestation with Denmark Funds, in Telpaneca. > Project on the improvement of soils and water sources of San Dionisio in Matagalpa. > Project about human rights, international agreements with ILO funds. > Health Plan 2004-2005.
Multi-countries Projects.	**RAAN:** > PAHO/WHO: TCC: Disability of Divers with Honduras/Nicaragua. > PAHO/WHO: TCC: Oral health in communities Miskito Honduras/Nicaragua.
Interinstitutional / intersectorial Forums.	**RAAN** > Regional Health Council 2 per year. Entity representing civil society, municipal governments, community commissions, leaders, municipal directors of MINSA, traditional medicine doctors, disabled, pastors, Universities. > Health Commission. MECD. > Fora on traditional medicine. > Forum about autonomy, health and decentralization.

2. Strategic Associations and interinstitutional / intersectorial collaboration networks (part 2)

Interinstitutional / intersectorial Forums.	**RAAS** > Community Assemblies. > Fora on autonomy, health and education > National assembly concerning water and environmental sanitation > National assembly about water and environmental sanitation in indigenous peoples > Pre-congress of Indigenous People. > 2 Fora on the Movement of Indigenous Women of Las Segovias. > Forum on Ethno mapping and VIII population census and IV housing census > Forum on national health plan. > Forum on international agreements of Indigenous People. **MINSA** > Forum on Grisi sickness (cultural diseases). > Meeting for national evaluation for the national health decade of Indigenous People. > Forum on Traditional Medicine. > **Indigenous Parliament of America** Seven territorial and theme Fora for consultation on the bill of Traditional Medicine and alternative therapies
Indigenous organizations which include health care/approach in their political agendas.	**RAAN:** Christian Medical Action, Unlimited Health, Horizon 3000, CEDERQUA, Red Cross, ALISTAR, Bilwi Clinic, IDSIM Morava Church) Santa Martha, Program of the Apostolic Vicariate, Save the Children Canada, Blind Organization Maricela Toledo, Women's Movement (Christians, Nidia White, Nora Astorga, Paula Mendoza) **RAAS:** Red Cross, Christian Medical Action, Women Movement, URACCAN, BICU, World Help, Peace Corps **APRODIN:** APRODIN. Esperanza del Futuro Association in Rivas.
Networks	**RAAN:** MASAKU, URACCAN, IMTRADEC, AMICA, Women's Movement Nidia White **RAAS:** YACAMA, AMICA, MIRAAS **APRODIN:** Regional Councils of Indigenous People Center North Pacific, Indigenous People located in both regions.

3. Primary public health care and cultural diversity (part 1)

Policies enhancing the incorporation of Indigenous perspective, medicines and therapies in National Health Programs.	*The current health policies* made by sectors includes the implementation of innovating health strategies in the Atlantic Autonomous Regions. The attention modality in correspondence with the local work and the ethnic and cultural characteristics is stated as a challenge. The strengthening of primary health care is oriented towards the promotion of an active and conscious participation to promote health in homes and community, incorporating the different alternative practices of Traditional Medicine. *In the autonomous regions,* the RAAN and Mayagna people health models stand out. The traditional Medicine and alternative therapies proposal of law, have the object of incorporating indigenous perspectives, medicines, and therapies in the national health system.
Experiences of the harmonization between the Indigenous health systems and conventional ones.	*Attention of patients* bit by snakes; in some cases where the childbirth care is provided by midwives and western medicine doctors, the health care of the mother and the child reduces the risk of maternal death. There are some isolated experiences in the treatment of pathologies attended by doctors and sukias. A model of harmonization experience is the attention of the Krisis Siknis situation, in the bank of the Coco River between Sukias and Occidental Doctors specialized in Mental Health of Central MINSA. Experiences of NGOs work implementing models of health care with intercultural focus as those presented by the Christian Medical Action and projects promoted by Horizonte 3000 (particularly in the development of RAAN and Mayagna health model). **The Red Cross implements the AIEPI PROJECT** which is health promotion and community exchange of experiences with the American, Dutch, Nicaraguan and Honduran Red Cross MINSA and PAHO. It produces educational material in miskita language validated by the communities. The Ministry of Labor has taken actions to reduce labor risks of Miskitos divers, by training promoters and promoting legal measures. MINSA with the support of PAHO, in the TCC framework with Honduras and Nicaragua has published educational material in miskito language to prevent diving problems. PAHO/WHO Nicaragua along with the counterparties of the Ministry of Health have developed several activities in the APS and inter cultural context: > Preparation of leaflets about dengue in creole, miskitu and mayagna. > Community AIEPI project in Waspam. > Health promoting schools in 11 indigenous communities of Matagalpa. > Training of indigenous organizations in Environmental Primary attention. > Sustainable agriculture projects without pesticides. > Actions to face intra family violence and suicide. > International Events about Traditional Medicine, disaggregation of information by ethnicity, health of afro caribbean population, indigenous environmental health, cultural adequacy of tuberculosis standards.
Associations of Indigenous therapists	It is unknown if there are association of indigenous therapists in the Atlantic Region. The Association of Traditional Medicine in Sutiaba was recently created.

Human resources formation and development Programs (research and scholarships).	**URACCAN**, with coverage in RAAN and RAAS develops training programs of human resources in a community level; students perform research in communities based on scholarships for youngsters of different communities. The Institute of Traditional Medicine and Community Development has the purpose of revitalizing and promoting the use of Traditional Medicine. It has held courses on management of community health, technical superior in nurse studies, graduate level in nursery, master degree in intercultural public health, that are diplomas for promoters with major in HIV/AIDS that benefit the municipalities of Siuna, Rosita, Bilwi, Waspam and Río Coco. **The MINSA-BICU Nurse School** in RAAS, (since 1980) has a program for the training of nurse aids, professional nurses with major in management and community, laboratory and surgical techniques aids. The students have educational training, attention in health, working in network, health symposia and inter sector coordination. They grant scholarships to students. **Cuba** has given scholarships to study medicine through autonomous regions for young Miskitos. **PAHO** held diploma studies in health for development (2003) that included a module on ethnicity and health. It granted scholarships to students of the Atlantic and Pacific Center North. It sponsors some trainings to APRODIN and participation in events abroad. In the **research area**, recently POLISAL Managua, Jinotepe, is linking the work of students of Nursing in Public Health with Indigenous People of Nancimi and Salinas of Nagualapa. Scholarships for indigenous resources for Salinas de Nagualapa and Nancimí for diploma studies on prenatal attention have been received.

4. Information, analysis, monitoring and management (part 1)

IInformation about the demographic, socioeconomic and epidemiologic profile of the Indigenous peoples.	No official studies available. The main approach on health of autonomous regions is obtained from the RAAN/RAAS data of the ENDESA and sanitary statistics of MINSA for these regions. PAHO/WHO performed an analysis of the socio economic demographic variables of access and health included in the national surveys of demography and health (ENDESA), and of the measure of life level (EMNV) according to the different ethnic groups, it has been recently published and disseminated. PAHO/WHO along with CIES and APRODIN performed a bibliographic compilation of national studies related to health of Indigenous People, found in more than 100 works. It is currently being processed. PAHO/WHO along with URACCAN performed a survey on health of ethnic communities in 2003, which is being completed and will be sent to participating communities. URACCAN has published several works on health situation for example, "Health situation of divers in Bilwi", "Knowledge, relieves and practices of traditional agents on most frequent diseases of Rio Coco Abajo, Waspam".
Information, monitoring, evaluation systems of the health of indigenous peoples. It includes the ethnic variable.	> Recently (January 2004) MINSA incorporated the variable of ethnic pertinence to the registry systems of health systems which will allow an analysis of service delivery, coverage, birth and mortality in the near future. > The information system as well as health care models of autonomous and mayagna regions are being consolidated. > There is a proposal for equipping of SICO. > SIAR, System of Environmental and Regional Information contemplates indicators related to Traditional Medicine, health, education and natural resources.
Localization maps of indigenous peoples inside the countries according to the country's political division. (Include the map in annex).	The Map of Indigenous Regions of Nicaragua (Updating of the Native Lands Map, National Geographic, URACAAN, with the support of PAHO/WHO y APRODIN) is available. Map of the indigenous people of Ramacay, in RAAS. Map of Indigenous People Matagalpa, San José de Cusmapa, Mozonte. Telpaneca.
Characterization of indigenous peoples in respect to their living and health conditions, social organizations as well as maintenance and recovery of their health.	> PAHO/WHO along with MINSA, MIN y APRODIN made studies of basal line health, cosmovision and cultural identity of the ethnias of Nahoa, Chorotega, Xiu, Cacaopera, Miskitus, Mayagnas and afrocaribe ancestors in the 1998-2000 period recently published and distributed. > IMTRADEC y URACCAN have some studies > There are available studies of basal line health and health plans for Indigenous People located in the Chorotega, Diriangen and Nicarao. > Community diagnosis of Nancimi, Salinas de Nagualapa and San Juan de Oriente. > Diagnosis of 11 indigenous schools of Matagalpa, characterization of the Cacaopera territory.

4. Information, analysis, monitoring and management (part 2)

Periodical publications about the health conditions of indigenous people	There are no periodical publications on health of the Indigenous People.
Section about the health conditions of indigenous peoples in the electronic page of the Ministries of Health, PAHO or other institutions (e-mail address).	PAHO Nicaragua: Web page on the theme of health of theIndigenous People.

Second part

1. What are the most relevant achievements concerning the health care of Indigenous peoples during the period 1995-2004?

> Nicaragua government is signatory of Durban Agreements and has started the process of monitoring these agreements.
> There is a wide legal framework that recognizes the rights of Indigenous People to autonomy, language, territory, education, and health.
> There is progress in the attention of Indigenous People and ethnic communities.
> An opening process of State and society towards health of Indigenous People, has been started.
> There is recognition and institutionalization of the health care models of autonomous regions.
> Ministry of Health has established a focal point for the special attention and facilitation of implementation of national health policy in zones with indigenous population
> Progress has been made in the Law of Traditional Medicine and complementary therapies, currently in the National Assembly.
> It has been guaranteed the participation of Autonomous Regions in the National Health Council.
> In general there have been important advances in the implementation of Primary Health care with cultural focus including training of human resources and research.
> Some efforts are recognized for collection, edition, diffusion, and bibliographic dissemination on Traditional Medicine and more recently in ethnicity and health.
PAHO/WHO contribution in this theme is recognized.
> The Mapping of indigenous regions of Nicaragua has been updated and specifically the ethno mapping of indigenous people Ramacay, Awastigni, and the process has started in Prinzapolka

2. What are the priority issues regarding the assistance to indigenous people health during the period 1995-2004?

> National Development Plan does not incorporate a development strategy from the vision of Indigenous People and ethnic communities; it is reiterated the lack of political will towards Indigenous People and general ignorance regarding the Millennium Development Goals. Indigenous People health still needs to be a priority and negotiate more support.
> The official attention model does not take into consideration particularities and cosmovision of Indigenous People.
> It is still to be defined how to strengthen the Traditional Medicine system as well as validating interventions, creating adequate mechanisms for official recognition and establish clear plans on this regard.
> The main health problem is extreme poverty and poverty of Indigenous People, degradation of environment, inequity in development and health, child labor, lack of education, and lack of integration of Traditional Medicine to the official model.
> Inaccessibility of services, persistence of linguistic social and economic barriers and the lack of specific programs and projects. As specific health problems are reported, undernourishment, infant mortality, maternal mortality, health problems of the mothers, HIV/AIDS/ITS and drug addiction.
> Limited development of human resources with inter-cultural capacity for the attention of indigenous communities.
> Mechanisms for social participation of traditional entities are not yet defined.

3. What are the aspects to be inserted into the indigenous peoples health as part of the priorities in the processes the country is promoting for the renewal of the Primary Assistance Strategy and the fulfillment of Millennium Goals?

> To prepare the ratification document of the ILO Agreement 169 and to submit the proposal to be signed before the end of the decade in December 2004.
> Establish a national policy for the development of Indigenous People and ethnic communities of the country and locally strive to increase budget allocation.
> Promote respect for the administrative autonomy of Indigenous People regarding natural resources.
> Promote strategies and inter sectorial actions to reduce child labor and widen the coverage of intercultural elementary education.
> Increase decentralization process.
> Incorporate inter cultural and gender focus programs promoted by MINSA and Nicaragua Government.
> In autonomous regions, the attention models are recognized; even though it is requested to share co execution of an attention model, and MINSA strengthening the process of autonomous regions and considering the attention to all Indigenous People of the country through an inter cultural adequacy of the current model.
> Establish mechanisms that facilitate to having a representative of Indigenous People and ethnic communities in national bodies, for example the National Health Council.
> Respect for cultural identity, indigenous knowledge, spirituality and knowledge of Traditional Medicine, and promote and rescue native and traditional knowledge. Government and institutions should be flexible and tolerant, and advance towards the integration of models.
> Include explicitly the health of the Indigenous People as a role of SILAIS. Create an instance in the definition and validation process of standards and procedures to be participative and proactive, guaranteeing the intercultural focus.
> Prepare an integral plan to train human resources with inter cultural focus.
> Incorporate the indigenous community network (Council of the Elders, chieftains) into the network of community agents and reorganize it as a sole network that corresponds to the need of these people, in accordance with the LGS.
> Promote a training program and advocacy on human rights and indigenous rights.
> Spread the Millennium Goals assumed by the country in different levels including the translation to the languages of the country.
> Spread sectorial health policies and national health plans in all the languages of the country in a proper way.

Strategic analysis	
Strengths: particular characteristics of the country which would facilitate the actions towards the improvement of the indigenous people's health.	**Weaknesses:** inner negative aspects of the country which would difficult the actions towards the improvement of the health of the indigenous people.
> Legal frame provided by the Constitution of the Republic. The laws and policies favor Indigenous People and contribute to the institutionalization of processes, advance of decentralization and creation of dialogue spaces. > Opening of Ministry of Health to implement an intercultural focus. > The National Health Council is a space of dialogue and participation of the commission of regional health. > Coordination of Indigenous People of the Center and North Pacific with the Ministry of Health; there are municipalities that incorporate indigenous representatives in local and municipal councils. > There is human capital in indigenous health with political and working will with SILAIS. > The organization of divers´ union allows to advance addressing specific occupation health problems. > Indigenous women are in the process of organizing at local levels and making decisions in the regional councils of Indigenous People. > Indigenous Women Elders are associated and participate in the Councils of Elders. > Health Model of RAAN approved by the RAAN Regional Council and recognized in the General Health Law. > URACCAN and BICU train community human resources. > Traditional doctors are more recognized and accepted and there is more openness for dialogue.	>Insufficient political commitment and opening of the State and its institutions. >Lack of adequate knowledge of agreements made at different levels and fields, and lack of monitoring and follow-up mechanisms of agreements. >Lack of convincement and acceptance of the State towards decentralization of Autonomous Regions. >Limited application of the in force legal framework. >Lack of consolidation of regional governments. >There is no autonomy in the indigenous territories of the original towns: majors and council members abuse of their power against the right of Indigenous People. >Inequity in national priorities. >Limited financial resources to attend the needs of Indigenous People. >Economic, financial cultural and functional barriers to health services access. >More discrimination towards indigenous women. >Lack of knowledge of the life and health condition of Indigenous People. >Invisibilization of the contribution of indigenous women in the development process of Indigenous People and the country. >Lack of integration of the Indigenous Health Council to Department and National Health Councils of MINSA.

Strategic analysis	
> Experiences complementing health systems with health care in different themes and localities. > Healthy indigenous schools and inter-cultural education plans. > Inter-sectorial work with emphasis in health promotion. > Environmental perspective incorporated in practices of environmental care and production without using pesticides. > Visibilization of Indigenous People of the Center and North Pacific Regions. > Map of indigenous regions.	> Limited technical capacities of health personnel regarding intercultural focus. > Limited institutional support for the development of autonomous health model. > There is no adequate integral attention for miskitos divers. > Regarding the Traditional Medicine approach, a structure like URACCAN is needed in the RAAS and in the Pacific. > Lack of indigenous health professionals. > High illiteracy index in indigenous communities especially among women. > Lack of continuity of the indigenous authorities in directive councils of health councils. > Limited consolidation of the indigenous national unity. Each regional council of Indigenous People works on their own agenda. The Indigenous Movement of Nicaragua MIN/CICA is currently represented at international level. There is a lack of links with the community work. > Discrimination of government towards Indigenous People. > Ignorance of rights of Indigenous People, particularly women´s rights. > There is no state authority and civil society that protects the property rights of the Indigenous People.
Opportunities: factors that exist in the context and it is believed they would act in favor of the actions aimed at improving the health of indigenous peoples.	**Threats:** negative factors that may affect the implementation of actions aimed at improving the health of indigenous peoples.
> Existing international and national legal framework that covers the human rights of the Indigenous People. > Dialogue spaces in State Institutions at municipal, departmental and national level. > Process of territorial demarcation to assure land holding.	> Lack of ratification by the government to the ILO Agreement 169. > Disperse and obsolete legal framework that damages the rights of the Indigenous People and increases inequity gaps. > Little interest of the government to support the enforcement of laws. > Breach of national laws in the frame of respect of indigenous rights. > Political fanatism.

Strategic analysis

- Inter cultural focus as a cross-cutting theme of health reform and as a dynamic element in the implementation of General Health Law, sectorial policy and national health plan.
- Recognition of regional authorities and opening of the Health Secretariat of Regional Government.
- General Health Law that recognizes the indigenous participation in the local municipal, departmental and national councils.
- Opening of MINSA, a cooperation agreement with APRODIN and agreements with autonomous regions.
- Traditional Doctors.
- Universities of the Pacific UNAN-Managua, UNAN León, POLISAL, CIES, as a reference to promote work with Indigenous People and improve the training of human resources.
- Adequate inclusion of the ethnic pertinence variable in the next National Census and National surveys.
- Empowering of Indigenous People.
- Natural resources of autonomous regions and Indigenous People.
- Solidarity of international cooperation.
- Health Program of the Indigenous People of the Americas, PAHO/WHO.
- Political interference of local governments increases conflicts of Indigenous People, limiting community development and autonomy.
- Lack of inter-cultural focus in the programmatic planning of the government that causes unemployment in indigenous communities, promotion of tourism in indigenous protected areas, lack of a strategy for the attention of the Indigenous People, rigidity of governmental institutions, change of authorities and lack of monitoring of agreements and activities.
- Destabilization of autonomous processes currently operating and the lack of advance in decentralization processes.
- Lack of attention in RAAS menaces the division of territories: El Ayote, Nueva Guinea, Rama and Paiwas that are requesting to be organized as departments.
- Expropriation and eviction of indigenous families from land belonging to indigenous territories by land owners, government and other entities are the cause of hunger, morbidity and food and family insecurity.
- Lack of legal advice from the Attorney General of Human Rights in the solving of conflicts with government related with usurpation of indigenous territories.
- Abuse of power from city halls and councilors in detriment of the rights of the Indigenous People.
- Turnover and drain of human resources, lack of updating of curriculum in ethnicity themes, and the lack of human resources in statistics.
- Risk of passive participation and no decision making of Indigenous People is allowed, limiting community development.
- Abolition of artisan diving fishing due to the high risk involved, but that would cause unemployment of miskitos workers.
- The Climatic change affects crops and increases the risk of hunger and undernourishment.

Third part

Table 1. Population and Indigenous peoples of Nicaragua

National Population	Indigenous Population (estimate)	%	Peoples
5.407.831	448.850	8,3	9

Source: Map of Indigenous Regions of Nicaragua, 2004.

Table 2. Challenges, factors to be considered and inequities (part 1)

Challenges

Health strategies and public health should encompass and face structural factors of risk and should be inserted in the strengths of the Indigenous People. Strategies should be oriented to:

- Development of inter-sectorial policies for Indigenous People.
- Fulfillment of legislation and ratification of pending agreements.
- Adequacy of a health model with inter-cultural focus.
- Integration of Traditional Medicine to health system.
- Integral training of human resources.
- Visibilization and generation of evidences.

Factors to be considered

- **Localization:** Afrocaribes (Miskitos, Mayagnas, Creoles, Ramas and Garífonas) ethnic communities are concentrated in the Atlantic Region of the Country, characterized by a very low population, high geographical dispersion and low geographical accessibility to utilities. The Miskito population is located in Nicaragua and Honduras, on both margins of the Coco or Wangki River.
  Indigenous People from Nahuatl, Cacaopera, Chorotega and Hokan Xiu ancestors, are distributed in 8 of the 17 departments of the country and in 35 municipalities (23% of the total). Higher proportion is located in Matagalpa, León, Masaya and Madriz departments. In terms of localization, 100% of Ramas, 61,6% of Miskitos and 90% of Mayagnas live
- in zones of high risk of natural disaster as compared with 31,8% of the average of the country.

Ethnic and Cultural heterogeneicity: Nicaragua is a multi ethnic and pluricultural nation in which ethnic communities represent approximately 8 and 9% of the population of the country. There are nine ethnic communities, five in the Atlantic (Miskitos, Mayagnas, Creoles, Ramas and Garífonas) and four in the Pacific, Center and North of the Country (Nahuatl, Cacaopera, Chorotega and Hokan Xiu). The Languages of these communities are officially recognized as official languages.

Table 2. Challenges, factors to be considered and inequities (part 2)

> **Culturally appropriate care:** In the Autonomous Region of North Atlantic has been defined an attention model just like the attention model of the mayagna people. There is legal and institutional recognition of Regional Health Councils. There is a project for the law of Traditional Medicine and alternative therapies that promote integration of Traditional Medicine to the health system. Even though there are specific experiences of integration at a local level, development is still incipient. Health Sector policy and health plan (2004-2015) state a favorable framework in autonomous regions and recognition of inter culturality.

Inequities

> **Poverty:** The analysis of recent national surveys on demography, health and measurement of health conditions (2001), shows socio economic differences: for example 70% of miskitos are poor as compared with 43% of the rest of the country. Comparing the annual income per capita by ethnia with the country average , we find that for ethnic communities, income is quite inferior to the country income per cápita (38% for Mayagnas, 54% Creoles, 59% Miskitos, 64% Ramas). Dependence index is 68,3% for Creoles and 35,9% for Miskitos, compared to the 26,5% of the country.

> **Illiteracy:** Illiteracy in heads of family affects 34% of Miskitos, 65% of Mayagnas (versus 28,8% of the country). School exclusion for children in preschool age affects 71% of Creoles, 75% of Mayagnas, 81% of Miskitos and 100% of Ramas against 53% reported for the country. Primary education affects 25% of Miskitos and 50% of Ramas, against 3,9% of the country. High School education 65,2% of Mayagnas are excluded in comparison with 38.9% reported for the country.

> **Unemployment:** : underemployment affects 83% of Creoles, 71,2% of Miskitos, 90,4% of Mayagnas, 100% of Ramas (versus 54% of the country). Labor insecurity is reported for 46,2% of Mayagnas, 50% of Ramas and 19,5% of Miskitos (versus 11,6% of the country). There is low productivity in homes 56,9% of Miskitos, 64,4% of Mayagnas and 100% of Ramas (versus 33% of the country).

> **Utilities:** Crowding affects 61.9% of Miskitos versus 38,1% of the country; the bad condition of houses affects 71% of Miskitos, 82,4% of sumos versus 65% of the country. No water closet 54,6% of Miskitos, 53,7% of Mayagnas and 100% of Ramas against 13,8% of the country). Bad provision of water affects 58% of Miskitos, 69,4% of Mayagnas, 100% of Ramas, as compared with 19,3% of the country. No electric power 62% of Miskitos, 90,4% of Mayagnas, 100% of Ramas versus 27,8% of the country. The access to basic services is a major problem, for example the average distance to health units is 8.8 km for Miskitos, 15,7 km for Mayagnas, 22,5 km for Ramas versus 3 km for the rest of the country. Likewise the distance to schools is 2 km for Miskitos, 3,1 for Mayagnas, 3,3 km for Ramas, against 0,9 km as average of the country. 47,5% of Miskitos have no accessible ways in winter (27,3% country) and in the afro caribbean communities in general less than 1,4% of the access ways have improved in the last years against 17% reported as average of the country.

> **Infant Mortality:** Infant mortality in the Atlantic regions is 43% higher than the country average (similar increments for neonatal and post neonatal) Post neonatal is 50% higher in RAAN. In general, the mortality rate in children is 33,3% higher in both regions of the Atlantic. 55,7% of Miskitos children and 100% of Ramas have no access to controls in growth and development against 24,6% of the country. 39% of children attended by MIFAMILIA in Waspam and Bilwi had incomplete vaccination schemes.

Table 2. Challenges, factors to be considered and inequities (part 2)

> **Maternal Mortality:** Maternal mortality in autonomous regions that concentrate ethnic communities have higher figures than 200 for 100.000 nvr, against 96,6 for 100.000 nvr reported as the country average in 2002.
Ethnic communities report less access to family planning services, pre natal control and childbirth care. For example, 29.3% of Miskitas mother did not have access to pre natal control versus 12.3% of the average of the country, 57.4% did not deliver their babies in institution versus 27.7% of the country.

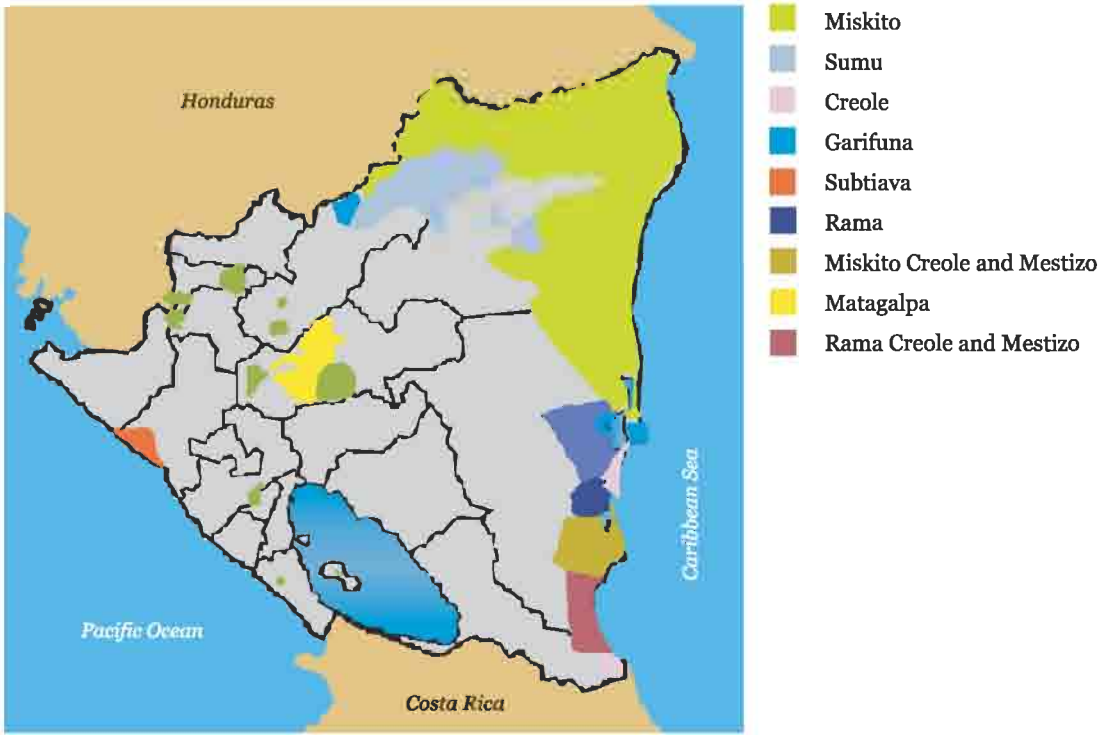
> **Undernourishment:** Chronic undernourishment affects 33.7% of Miskitos children and 100% of Ramas versus 19.6% of the country. Global undernourishment affects 12.8% of Miskitos versus 8.9% of the country. Miskitas communities only consume an equivalent of 70% of food consumption per cápita average of the country, 49.8% do not cover the basic food versus 34% of the country.

> **Infectious Diseases:** It is reported a higher incidence of malaria falciparum and tuberculosis in indigenous regions of the Atlantic. More than 90% of the malaria cases due to P Falciparum are concentrated in 24 municipalities with indigenous population.

> **Diabetes, obesity, alcoholism:** Alcoholism and drug addiction are mentioned as part of priority health problems in the Atlantic. Regarding diabetis and obesity no data is available.

> **Suicide:** No data available.

Indigenous peoples in **Nicaragua**



Panama

1. International Agreements and National policies.

International Agreements	Legal Framework		Technical Units responsible for the health of indigenous Peoples	
	Constitution/ National Policies	Health Policies	Government Bodies/ Ministry	Contact Information
Resolution CD37.R5. Resolution CD40.R6.	**Act No. 16**, February 19th 1953 creates the Kuna Yala region. **Law No. 22** of November 8th, 1983 that creates Emberá Wounnan region. **Law No. 24** of January 12th, 1996 that creates Madugandi region. **Law 10** of March 7th, 1997 that creates the Ngobe-Buglé region. In 1999, it was decreed as the third goal of the Social Agenda of the country, "to establish a policy with and for indigenous people"	Ministerial Resolution of August 2nd, 1999 that creates the Unit of Traditional Medicine of the Ministry of Health (MINSA). Executive Decree No. 117 of May 9th, 2003 that creates the National Commission of Indigenous Traditional Medicine and Technical Secretariat.	> Section of Indigenous People and Traditional Medicine of the National Direction of Health Promotion, Ministry of Health. > Indigenous Policy of the Government and Justice Ministry. > Unit of Indigenous People of Youth, Children, Women and Family Ministry. > National Council of Indigenous development, created in 1999 at coordination level between government authorities and indigenous people	> Ms. Margarita Griffit E-mail: margaritapa2000@yahoo.com > Ms. Dorian Ríos > Ms. Hilda Thompson

2. Strategic Associations and inter institutional / inter sector collaboration networks

Agreement of Health Program of Indigenous People	> Non-existent to date.
Inter institutional/ inter sectorial Projects of Health Program of Indigenous People	> Project for biodiversity protection and adequate use of medicinal plants financed by the Fund of United Nations for Environment, starting 1999. > Project for the improvement of sexual and reproductive health of Ngobe-Buglé people, financed by the Population Fund of United Nations starting 1999. > Project of inter-culturality and gender financed by IDB, in year 2000. > Project for the prevention of tuberculosis in high risk areas financed by the Global Fund of United Nations starting 2003. > Project for malaria prevention in indigenous communities financed by MINSA, starting 2003.
Multipais Projects.	> Regional Project to impact on the prevention and control of dengue fever using COMBI strategy financed by PAHO starting 2004. > Regional Project for surveillance of quality of water in indigenous communities financed by PAHO, starting 2004.
Inter institutional / inter sectorial Fora.	> "National Forum of Indigenous Youth." For annual forums were held starting 1999, financed by IDB. > "Forum of Indigenous Women". Financed by UNFPA in 2001. > "Forum of Indigenous Non-Governmental organizations". Financed by IDB in 2001.
Indigenous organizations that include health care/approach in their political agendas.	> National Coordinator of indigenous women. > National Coordinator of indigenous people. > Congress of Kuna culture > Congress Emberá Wounnan. > Congress Ngöbe-Buglé. > General coordinator of Ngöbe-Buglé women. > Organization for the development of Ngöbe woman > Indigenous Center for development and environmental conservation.
Networks	> Infant indigenous network. > Indigenous network of biodiversity. > Indigenous juvenile network.

3. Primary health care and inter-culturality

Policies enhancing incorporation of Indigenous perspective, medicines and therapies in National Health Programs.	> Creation of Indigenous Traditional Medicine Section in 1999, ascribed to the National Direction of Health Promotion of MINSA, in 1999. > Executive Decree No. 117, of May 9th, 2003 creates the National Commission of Indigenous Traditional Medicine and Technical Secretariat of Traditional Medicine of Indigenous People.
Experiences of harmonization between Indigenous health systems and conventional ones.	> In the Ngobe-Buglé region, a Center for the training of Traditional Doctors has been implemented. > With the support of the IDB, two encounters of traditional doctors was held at national level in 2002 > In 2003, the Institutional Garden of Medicinal Plants with 15 plants scientifically validated by MINSA and University of Panama was created.
Associations of Indigenous therapists	> Association of Emberá Wounaan Traditional Doctors. > Association of Ngobe-Buglé Traditional Doctors.
Human resources training and development Programs (research and scholarships).	> Starting 2004, MINSA performed the Census of Traditional Doctors at a national level. This census is still being performed. > Through IDB, a consultancy service was performed in year 2000 for issuing of a methodological guide for the design of educational material with an inter cultural approach. > Through TRAMIL Program for the adequate use of medicinal plants, are offered seminaries workshops for health officers regarding articulation of traditional and western medicine.

4. Information, analysis, monitoring and management

Information about the demographic, socioeconomic and epidemiologic profile of Indigenous People.	X National Population Census and VI of Housing, May 14th, 2000. "Health of Indigenous People: An analysis of health conditions of indigenous population of Panama". Ministry of Health, PAHO, year 2000.
Information, monitoring, evaluation systems of health of indigenous peoples. It includes ethnic variable.	Health statistics of each region of the country. Only health regions located in indigenous region include ethnic variable.
Localization maps of indigenous peoples within the countries according to the country's political division. (Include the map in annex).	Map attached. *(page. 244)*
Characterization of indigenous people regarding to their living and health conditions, social organizations as well as maintenance and recovery of their health.	Non-existent to this date.
Periodical publications about health conditions of indigenous people	PAHO/WHO- Representation Panama: http:www.ops.org.pa
Section about health conditions of indigenous people in the Web Page of the Ministry of Health, PAHO, or other institutions (e-mail address).	

Second part

1. **What are the most relevant achievements concerning the health care of the Indigenous people during the period 1995-2004?**

> A greater alliance with traditional authorities of each people by Ministry of Health.
> Greater understanding of officers of the Ministry of Health regarding cultural differences of indigenous people and of the need of incorporating intercultural focus to health programs designed.
> Training of indigenous personnel as health promoters, nursing aids, nurses and doctors as well as their incorporation to the health system.
> Creation of Health Region of the Ngobe-Buglé region in 1998.
> Local level declaration of indigenous areas as emergency zones, to assign health and environment budget.

2. **What are the priority issues regarding the assistance to the health of the Indigenous people during the period 1995-2004?**

> Infant morbidity and of children of less than 5 years in indigenous areas.
> Sexual and Reproductive health.
> Undernourishment.
> Tuberculosis.
> Vector transmitted diseases.
> Environmental sanitation.
> Provision of basic health services

3. **What are the aspects to be inserted into the health of the Indigenous people as part of the priorities in the processes the country is promoting for the renewal of the Primary Assistance Strategy and the fulfillment of Millennium Goals?**

> Strengthening of the program of integral attention of diseases prevalent during childhood.
> Women health promotion and safe maternity guaranteeing the application of the obstetric and non obstetric reproductive risk focus.
> Development of food distribution and marketing programs and projects with the participation of the community and inter-sectorial support.
> Improvement of service network in the management, infrastructure, equipment human resources and training aspects.
> Promotion of organization and participation of indigenous community in the care and self management of health.
> Development of plans and projects for water supply and quality, and environmental sanitation.

Strategic analysis	
Strengths: particular characteristics of the country which would facilitate actions towards improvement of indigenous people's health.	**Weaknesses:** : inner negative aspects of the country which would difficult actions towards improvement of indigenous people's health.
> Specific unit within the Ministry of Health to address health and traditional medicine in indigenous areas.	> Tight institutional budget assigned to the health attention of indigenous people. > Lack of motivation of health personnel to work in indigenous areas.
Opportunities: factors that exist in the context and are believed they would act in favor of the actions aimed at improving health of indigenous peoples.	**Threats:** negative factors that may affect implementation of actions aimed at improving health of indigenous peoples.
> International bodies, namely UNFPA, IDB, Global Fund, GEF, PAHO, that currently cooperate in implementing Projects and programs in indigenous areas.	> Lack of unity and rivalry among the seven indigenous people of Panama. > Panama has not ratified ILO Agreement 169

Third part

Table 1. Population and Indigenous peoples of Panama (population in thousands of inhabitants)

National Population	Indigenous Population (estimate)	%	Peoples
2.800	232	8	7

Source: X National Population census and VI of housing of may 14th, 2000.

Table 2. Challenges, factors to be considered and inequities (part 1)

Challenges

The models and practices of the health sector that are developed in indigenous communities should be reoriented on a basis of a new inter cultural focus that recognizes the cultural diversity of indigenous groups, their traditional health systems; and provides a specific answer to particular health conditions of this population. It should include:

> Higher coverage of medical services.

> More personnel and training to perform in these areas.

> More availability of medicines.

> Emphasis in the development of prevention programs that incorporate consultation with communities and traditional leaders.

Factors to be considered

> **Localization:** Even though there are five regions legally recognized, where 63% of indigenous population lives, it is difficult to have access to the communities due to lack of roads.

Furthermore there is a percentage of indigenous population dispersed in different provinces of the country.

> **Traditional authorities:** Indigenous people of Panama have a strong traditional organization, especially in the case of the Kuna whose leaders have the last word in the decision making. In may cases mobilizations and projects of health sector have been detained due to lack of previous consultation with traditional authorities.

> **Migration:** Indigenous population of Panama has constant migration patterns in the search for employment education, health and better quality of life. This continual mobilization of persons enables dissemination of diseases as HIV/AIDS, tuberculosis, malaria, among others. Furthermore it makes a difficult assignment when adequating attention and monitoring to indigenous population.

Inequities

> **Poverty:** The general poverty level nationwide is 40%, but in indigenous areas is 95%. The average national income per capita is 2.850,00, and the indigenous average per capita is 712,00 (PRONAM; 1998).

> **Life expectancy:** Thehealth situation of indigenous population has serious problems compared with the rest of the population. Life expectancy at national level is 72,4 years, while it is 63,4 years in areas of indigenous population. (PAHO, 1998).

> **Infant Mortality:** Panama has a high rate of infant mortality, 17,6 per 1.000 born alive. In the indigenous areas this rate is four times higher than the national average value; estimated in 60 for 1.000 born alive, even though there are places with figures higher than 84,1 per 1,000 born alive(ENV, 1997).

> **Maternal Mortality:** The rate of maternal mortality is estimated in 6 per 10.000 born alive in 1997. For the Kuna region it was 44 per 10.000 born alive and this is one of the highest rates in the world. For other regions of indigenous population, the average was 15 per 10.000, approximately three times higher than the national average. (PAHO, 1998)

> **Undernourishment:** Undernourishment affects 17,7 % of Panamanian population, it affects 68% of the population. One out of two indigenous children present certain undernourishment degree, while in the rest of the population, it is one for every ten. (ENV 1997)

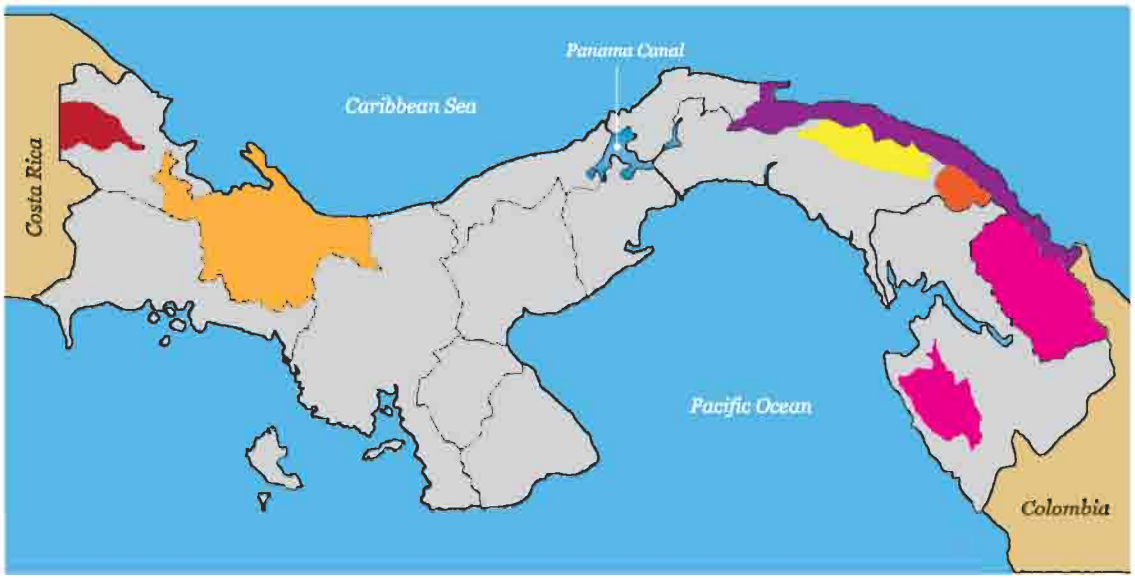
Table 2. Challenges, factors to be considered and inequities (part 2)

> **Illiteracy:** The National Illiteracy Average for the population over 10 years is 31,2% compared to the indigenous population that is l4,3%. This situation is more accentuated in women and elders. (National Census, 1990)

> **Environmental sanitation:** Water coverage in rural area is 78%, against 20% in indigenous area. Approximately 40% of water for this population is obtained from rivers and water courses. Regarding sanitary installations it is estimated that half of indigenous homes does not have connection to sewerage or latrines. (ENV, 1997)

> **Infectious diseases:** Vector transmitted diseases as malaria and leishmaniasis have the highest rates in indigenous population. In the case of tuberculosis, national rate is 35,8 for 100.000 inhabitants, but in the indigenous area it is 139 for 100.000 inhabitants. (PAHO, 1998)

Indigenous peoples in **Panama**



Naso Teribe
Ngöbe-Bugle
Madungandi
Kuna Yala
Wargandi
Emberá-Wounaan

Panama Indigenous Population (X National Census, year 2000)

Population	Absolute	Percentage
Ngobe-Buglé	149.898	64,5
Kuna	58.100	25,0
Embera-Wounaan	20.916	9,0
Naso	2.324	1,0
Bri-bri	1.162	0,5

Comments

Panamanian indigenous people are privileged in comparison to other indigenous people of the Americas because they have a legally assigned land; besides the laws recognize their autonomy, culture and traditional medicine. We have a lot writen but the challenge we have as a country is to materialize theses laws and rules. In order to achieve it, the approach of the situation of the indigenous people in an integral and not isolated way is needed, just as it has been done until now. It is impossible to implement an infant vaccination program without considering the need of implementing a nutrition program, poverty eradication, education, and environmental sanitation. This requires the development of inter-sectorial projects in close coordination with indigenous traditional authorities. Working in cooperation is the only way to decrease existing inequities and contribute to improve the life quality of this people.

Paraguay

1. International Agreements and National policies.

International Agreements	Legal Framework		Technical Units responsible for the health of indigenous Peoples	
	Constitution/ National Policies	Health Policies	Government Bodies/ Ministry	Contact Information
Health Initiative of Indigenous People of the Americas. April 1993. Winnipeg, Canadá. PAHO/WHO. International Decade of Indigenous People 1995-2004. Resolution V PAHO/WHO resolution that approves health initiative 1993. Resolution VI PAHO/WHO 1997. Consultation on Indigenous Health 1999. Geneva WHO/HSD/00.(2)	**National Constitution of Indigenous People.** *Chapter V. Art. 62 to 67*explica explains recognition of existence of indigenous people and other ethnic groups	National Health Policy of Nicanor Huerta Frutos government 2003-2008. Seminar"Particularities of indigenous communities and new rural settlements in Paraguay: incidence in Health". PAHO/WHO/MSPBS. 1991. National Health Policies. 1991 to 2003.	> Paraguayan Institute of Indigenous (INDI) > Public Heal and Social Welfare Ministry. General direction of health services	> Mr. Oscar Centurión Tel. (595)2144-0739 E-mail: indipy@telesurf.com.py > Dr. Silvio Ortega Tel. (595)2120-4688

2. Strategic Associations and inter institutional / inter sectorial collaboration networks (part 1)

Health Program Agreement of Indigenous People	
Inter institutional/ inter sectorial Projects of Indigenous People Health Program	> Prodechaco Project. Agriculture and Livestock Ministry (being concluded). > Pai Tavytera Project Capitan Bado.Amambay-XIII R.S. MSPBS. > XIII Sanitary region. Amambay-MSPBS > Association of Indigenous Communities Pai Tavytera Pai Reta Joaju: Training of PVS and traditional midwifes. UNICEF 1992-2003. > Boquerón Project. Canadian International Cooperation/PAHO/WHO. > Inter Ethnic Radio Communication Project. Canada Fund. Indigenous Association of Paraguay. > LINAJE Eco-poultry Project. Etnia Ava Guaraní. > Projects that partly include indigenous population: > Sexual and Reproductive Health Project. PAHO/WHO > TB Control and Prevention Global Fund Project > PAF/ONUSIDA. Prevention and Treatment of HIV > Project of assurance of indigenous health (in process)
Multi-country Projects.	
Inter institutional / inter sectorial Fora.	Indigenous shared Forum of Chaco Argentina-Paraguay. First version in La Estrella, Salta October 2003. Second version Fischat, Paraguay October 2004.
Indigenous organizations which include health attention/approach in their political agendas.	**Indigenous Organizations** > Association of Indigenous parcels. > Federation of Guarani Indigenous Organization of the Oriental Region of Paraguay. > Nivaklé People. Coordinator of Indigenous People of the Pilcomayo Basin. > Organization of Indigenous People of the Occidental region. > Commission of Indigenous People and Communities of Paraguayan Chaco. > Indigenous House. > Indigenous Social Center. > Space for Indigenous Participation. > TEKOHA > Indigenous Association of Paraguay (AIP). > Association of Health Promoters of Bajo Chaco. > Altervida. > Tierra Viva.

2. Strategic Associations and inter institutional / inter sectorial collaboration networks (part 2)

Indian organizations which include health attention/approach in their political agendas.	> Other Institutions. > Pilcomayo Apostolic Vicariate. > Hermanos del Río Foundation. > Survival > Association of Indigenous Menonita Communities (ASCIM). Filadelfia. Boquerón. > Indigenous Pro-Communities Filadelfia. > Defense Area of the Indigenous Heritage of Catholic University. > National Coordinator of Indigenous Pastoral (CONAPI). > Ayoreo Support Group (GAT) - Totobiegosode in their fight for land. > OGUAZU > Service of Indigenous Support (SAI). > SPSAJ > Socio Anthropologic and Legal Professional Services. > Iglesia de Jesucristo los Santos de los Últimos Días.
Networks	> Coordinator of Indigenous People and Communities of South America Chaco. > Network of Indigenous Organizations of Paraguay. > Network of Non Governmental Organizations to the service of Indigenous People of Paraguay. > POJOAJU. > Association of Non Governmental Organizations of Paraguay.

3. Primary health care and inter-culturality

Policies enhancing the incorporation of indigenous perspective, medicines and therapies in National Health Programs.	> Bill for creation of indigenous health sub system. UNICEF-CONAPI-MSPBS-Pediatrics Paraguayan Association-Oguasu-Others.
Experiences of the harmonization between indigenous health systems and conventional ones.	> Boquerón Project. Canada International Cooperation/PAHO/WHO. Paraguay. Tel. (595)2145-0495 > Mini project: Collection and identification of medicinal plants of indigenous people of Paraguayan Chaco (Prodechaco). > Assistance to indigenous communities through Health Mobile. > Dispensary Creation Project for Health Attention in Boqueron Department. > Guaraní Ñandeva Project.
Associations of indigenous therapists	
Human resources training and development program (research and scholarships).	> Boquerón Project, Chaco, CIDA/PAHO. > Permanent training of voluntary health promoters, nursing aids and empiric midwives. > Gran Chaco Paraguayo Project. Training of laboratory technicians and hospital management. > Cuba / Paraguay Intergovernmental Agreement for training of Paraguayan doctors.

4. Information, analysis, monitoring and management

Information about demographic, socioeconomic and epidemiologic profile of Indigenous People.	> Paraguay. Final Results. National Population and housing Census. Year 2002. Total of country. Technical Planning Secretariat. DGEEC Publications. > II National Indigenous Census of Population and Housing 2002. Indigenous People of Paraguay. Indigenous results. > Technical Planning Secretariat DGEEC, Publications.
Information, monitoring, evaluation systems of indigenous people health. It includes ethnic variable.	Information, monitoring and evaluation system of Public Health and Social Welfare Ministry registers activities performed by sanitary region, but without discrimination of ethnics.
Localization maps of indigenous people inside the countries according to country's political division. (Include map in annex).	> See attached map. *(page. 260)* > See Atlas of the Census of Indigenous Communities as per 1992 census (D.G.E.E.C).
Characterization of indigenous peoples in respect to their living and health conditions, social organizations as well as maintenance and health recuperation.	> Anthropologic Supplement. CEADUC > Catholic University "Our Lady of Assumption". > Melia publication on diagnosis of Indigenous People on basis of 1992 census
Periodical publications about health conditions of indigenous people	
Section about health conditions of indigenous people in the Web page of the Ministry of Health, PAHO or other institutions (e-mail address).	

Second part

1. **What are the most relevant achievements concerning the health care of Indigenous people during 1995-2004 period?**

> One of the principal achievements in this period is the indigenous population and housing census held on 2002.

> In 2001 the Human Rights Commission issued several recommendations to the Paraguayan government in relation to indigenous people. It was specifically recommended to health sector:

1. To adopt as soon as possible measures needed to favor indigenous communities and improve implementation and access to the health services.
2. To perform preventive health and sanitary assistance actions with special emphasis in the efforts to reduce the high undernourishment rates, infant mortality and tuberculosis and fight and prevent Chagas Disease and malaria.
3. To improve education services and its quality respecting cultural diversity and making effective the right to a compulsory elementary and free education, including educational measures needed to reduce the drop out and illiteracy rate.
4. To adopt the measures needed to protect ecologic deterioration to the habitat of indigenous communities with special emphasis in the protection of jungle and water which are basic for the health and survival as communities.

Paraguayan government has taken following steps to observe these recommendations:

1. INDI along with Ministry of Health, Ministry of Justice and lab, Ministry of Education and Culture and National Emergency Service of the Interior Ministry has provided medical assistance, provision of food and education.
2. The Ministries of Public Health and Social Welfare have strengthened the Primary Health care by implementing care with brigades that are in charge of medical and odontological care, immunization, construction and equipment of centers and health posts, installation of radio communications, transport system (motorcycles) in different indigenous communities, provision of medicine in sanitary regions, all these through agreements with international organisms and NGOs.
3. It is currently dedicated to put in execution the Paraguay Social Promotion and Protection Network that includes provision of food and assurance to access health services where priority sector is constituted by indigenous people.
4. In the environmental area, the proposal for creation of the General Direction of Environmental Health is in operation.
5. The Project for the supply of water to indigenous communities in the Oriental and Occidental Region is also being implemented. In the occidental region in the different groups, 90 systems and rehabilitation of 7 water supply systems have been implemented. Regarding Oriental Region, 21 water supply systems have been improved.
6. The Foundation "First Lady of the Nation" has performed important actions to obtain financing and external cooperation to foster and execute programs of integral support to indigenous communities. It was also launched the program for sanitary assistance, odontology, environmental sanitation, and provision of medicines. In his first month as President, Nicanor Duarte Frutos has visited the Paraguayan Chaco to know and verify the condition of indigenous communities that were facing difficulties because of the drought in the zone. After the visit, several government institutions with the support of private enterprises and non governmental organizations held a campaign for provision of water and food for those communities as well as sanitary assistance.

7. The state, considering the recommendations of the Human Rights Commission will control the fulfillment of the recommendations, especially those related to the preservation of environment and the right to education.
8. In general, there have been important achievements as it has been improved the Exchange of opinions among indigenous and public institutions. Furthermore, traditional treatment has been revaluated. Training and education has made indigenous conscious of their rights regarding health. Promoters have worked intently regarding health themes with leaflets written in their languages.

In the Central Chaco region and with the Ayoreo Totobiegosode of the Zamuko linguistic family.

1. The establishment of promotion actions and health prevention in Ayoreo Totobiegosode de Arocojnadí, Chaidi communities and for the Areguedeurasade (group of the jungle that in March 2004 held an encounter with their Totobiegosode relatives in lands of their domain) established in the Natural and Cultural Heritage Ayoreo Totobiegosode of Alto Paraguay:
2. Graduation of professional nurses that accompany communities to Boquerón Project (Canadian International Cooperation/ PAHO/ WHO) in the frame of training program in indigenous and conventional health held in the 17th, Sanitary Region of the Boquerón department.
3. Graduation of nursery aids for the attention of indigenous communities of the three sanitary regions of the Chaco (Pte. Hayes, Boquerón and Alto Paraguay) through the Prodechaco Project.
4. Articulation and implementation of attention and control mechanisms of prevalent diseases, reproductive health, dentistry care, immunization, and exoneration of attention in all the sanitary regions where there are indigenous communities.

- The most important impact of the health actions in the indigenous communities in the last decade, is the important reduction of general mortality caused by tuberculosis and principally the infant mortality. The process started two decades ago,it is registered according to the analysis of such indicators of the 1992 and 2002 population census ; as well the significant increase of population starting with the implementation of national immunization programs in indigenous communities caused an impact. A partial achievement has been the legal assurance of land pertaining to Guarani ethnia of the Oriental region even though there is still a social debt towards Mbya ethnic and some of the chaqueñas as the result of the application of Law 904/81.
- Other achievement is the training of voluntary health promoters and traditional midwives with different focus in the Occidental and Oriental region of the country, also made with the discontinued support of the agencies of international cooperation and sanitary regions. Even though this capacitation has been consolidated within indigenous organizations and communities with its impact in health improvement considering the mentioned indicators, and have succeeded in having their rights to health services recognized although discrimination still persists.
- Regarding continued education the slow literacy process in most of the Guarani groups in the oriental region is directed towards inter cultural bilingual education and this year has started in Amambay, the literacy program in Spanish "I can", one in Pai Tavytera and other in Ava Guarani (Itaguasu and Guarani colony).

2. What are the priority issues regarding the assistance to indigenous people's health during the period 1995-2004?

> There are some limitations for the access of indigenous people to health, namely:

1) cultural limitations;
2) accessibility and
3) care.

> Weakness in planning, executing and evaluating health programs implemented in indigenous communities, in sanitary regions that have the same limitations of physical resources (vehicles, health infrastructure near their communities); human (health teams with socio anthropologic knowledge and appointed to work with them, health services without racial discrimination and financial (budget limitation for fuel and per diem for work in the communities).
> Regarding cultural limitations it can be mentioned that in health services there is health personnel that knows the specific language of the different indigenous people in order to maintain fluid communication. Indigenous nursery aids and health promoters have been trained. Regarding distances and availability of health services it should be mentioned the establishment of dispensaries for attention in several indigenous communities, especially in the Boqueron Department which is in charge of volunteer health promoters trained by the sanitary region and that have radio communication system to transfer cases that demand hospitalization.

In general, problems are due to:

> Demographic profile and socio economic and cultural variables in issuing government policies and priorities. In the information system there is no variable of ethnic belonging, only of gender. This situation is because in general it was considered that the differentiation among indigenous communities and population in general was a discrimination factor for indigenous sector and thus it was adopted the term of vulnerable population that covers indigenous, rural establishment and elders.
> An attention model that has ethnicity data in the frame of Regional Plan of Indigenous Health.
> Promotion of reflection spaces with total participation of people interested regarding legalization legitimating of indigenous traditional medicine and indigenous traditional therapists, as well as the promotion of therapists associations based on ethic codes prepared by the therapists.
> Land registration to most of indigenous population.
> Institutional weakness in the decentralization process of policies and programs of the Health National Plan destined to indigenous communities.
> Need of active implementation of programs and agreements in the frame of National health System among sanitary regions of the country with the purpose of optimizing the coverage of general and special services to indigenous communities.

3. What are the aspects considered to be inserted into the health of the indigenous people as part of the priorities in the processes the country is promoting for the renewal of the Primary Assistance Strategy and the fulfillment of Millennium Goals?

- Incorporate the ethnic pertinence variable in the process of collecting information and the preparation of policies in order to have trustable indicators without this being considered as discrimination and that allow measuring of progress towards goals.
- Incorporate traditional medicine systems for health prevention and curing so as to provide the required attention without leaving aside cultural characteristics of each indigenous community.
- Provide services that take into consideration ethnic multi culture in order to facilitate access to health.
- FACE health attention of indigenous people taking into consideration models that integrate life style, income and place of residence.
- Strengthen decentralization process of national health plans and programs serving specific inter cultures.
- Strengthen implementation of the already designed program of Integrated Attention of Prevalent diseases of Infancy (AIEPI) and maternal-infant health.
- Strengthen Chagas, TBC, AIDS, ITS control programs, among others.

Strategic analysis

Strengths: particular characteristics of the country which would facilitate the actions towards improvement of health of the indigenous people.	**Weaknesses:** inner negative aspects of the country which would difficult the actions towards the improvement of the indigenous peoples health.
> The National health policy includes in its short term action plan strengthening of integral programs for health attention in rural establishments, indigenous population and elders through itinerant health teams. > Indigenous population in Paraguay has grown in 1981-2002 period; most of them maintain their ethnic identity.	> Need of incorporating demographic profile and socio economic and cultural variables in the issuing of policies and priorities of the government. > Information system does not have the ethnic belonging variable. > It is not yet general an attention model that responds to the real needs of the population. > Even though popular medicine is dominant in the country there is no legalization legitimating of traditional indigenous medicine and of traditional indigenous therapists. > High poverty levels.

Strategic analysis	
	> Development of not adequate health services to the expectancy of indigenous communities. > High prevalence of infectious diseases (TBC). > Limited effect of the activity for primary prevention. > Deficient environmental sanitation.
Opportunities: factors in the context and that are believed to act in favor to improving health of indigenous peoples.	**Threats:** negative factors that may affect implementation of actions aimed at improving health of indigenous people.
> Issuance of Millennium Goals with the purpose of supporting indigenous people and other ethnic groups in general for the strengthening of decision making and incorporation of processes for its achievement. Access to international support for development of primary health care and self determination of people.	> Lack of social and health policies directed to the conservation of ethnics can cause loss of culture and people in future. > Slow decentralization processes in zones of concentration of indigenous population. > Occupation of their ancestral territories.

Third part

Table 1. Population and Indigenous people of Paraguay (population in thousands of inhabitants)

National Population	Indigenous Population (estimate)	%	Peoples
5.163	89.169	1,7	20

Source: Paraguay. National Population and housing census 2002. General Direction of Statistics, Surveys and Census.

Table 2. Challenges, factors to be considered and inequities (part 1)

Challenges

> **Health and Public Health Strategies:** Even though no health policy has been defined for indigenous population, these people are included into the Health Policy of the Government which is directed towards social protection with equity, assuring concrete priorities in public health. Among the principal strategies to obtain equity in health access there are: foster sanitary reform, increase coverage of social security extending it to 1.500.000 persons. Foster programs of integral care with active participation in the community and jointly with other institutions in order to stimulate inter-sectorial coordination (National Health Policy of the Government of Nicanor Duarte Frutos 2003-2008).

Factors to be considered

> **Localization:** Half of the indigenous population lives in the oriental region and the other half in the occidental region. There is a high concentration in only five departments of the country: Boquerón and President Hayes (jointly they concentrate 45,4%), followed by Amambay, Canindeyú and Caaguazú, all of low density, exception made of the last department. Only 1,7% of this population lives in Asunción and the Central Department. 91,5% are located in rural areas. Nivacle, Occidental Guaranies and Ayoreos are considered multi national (Census, 2002).

> **Ethnic and Cultural Heterogeneity:** National Census shows a total of 89.169 indigenous people pertaining to 20 ethnic groups from which those with higher population volume are the Mbyá, Ava Guaraní, Paí tavyterá, Nivaclé, Enlhet Norte, Enxet South and of lesser population the Manjui, Tomarahó and Guaná ethnics. They are distributed in 412 communities, 150 towns, 31 nucleus. They constitute 1,7% of the total population of the country (2002 Census).

Culturally adequate care: Inequities

> **Poverty:** 95,1% live in rural zones with a fertility rate of 6,3, which is twice the national fertility rate (3,9) (2002 Census).

> **Illiteracy:** Global illiteracy rate in those older than 15 years is 51,1%, while that of the country is 7,1%. Regarding schooling, indigenous population has 2,2 years while at national level it is 7,0 (2002 Census).

> **Utilities:** In general and based on estimates obtained from 18 indigenous communities of the Chaco, 91% of the populations have access to water of the community cutwater and 7,3% with community wells. Only 10% have access to common latrines in general, half of them have access to latrines in bad conditions and 38% go to the forest. (Health Situation of Indigenous Communities of Paraguay Chaco2000).

> **Infant Mortality:** mortality rate estimated in the data of 1992 Census was 106,7 for every one thousand born alive with variations among people of 64,3 for every thousand born alive in the Maká people at 185 per one thousand born alive in the Chamacoco people. In the departments of higher concentration of indigenous population with at least 1 NBI is around 87%. (Health profile of Occidental Region 1998).

> **Undernourishment:** Chronic undernourishment grade III for the Boqueron Department was 85% in children under under 4 years in 1994 (Health Profile of the Occidental Region, 1998).

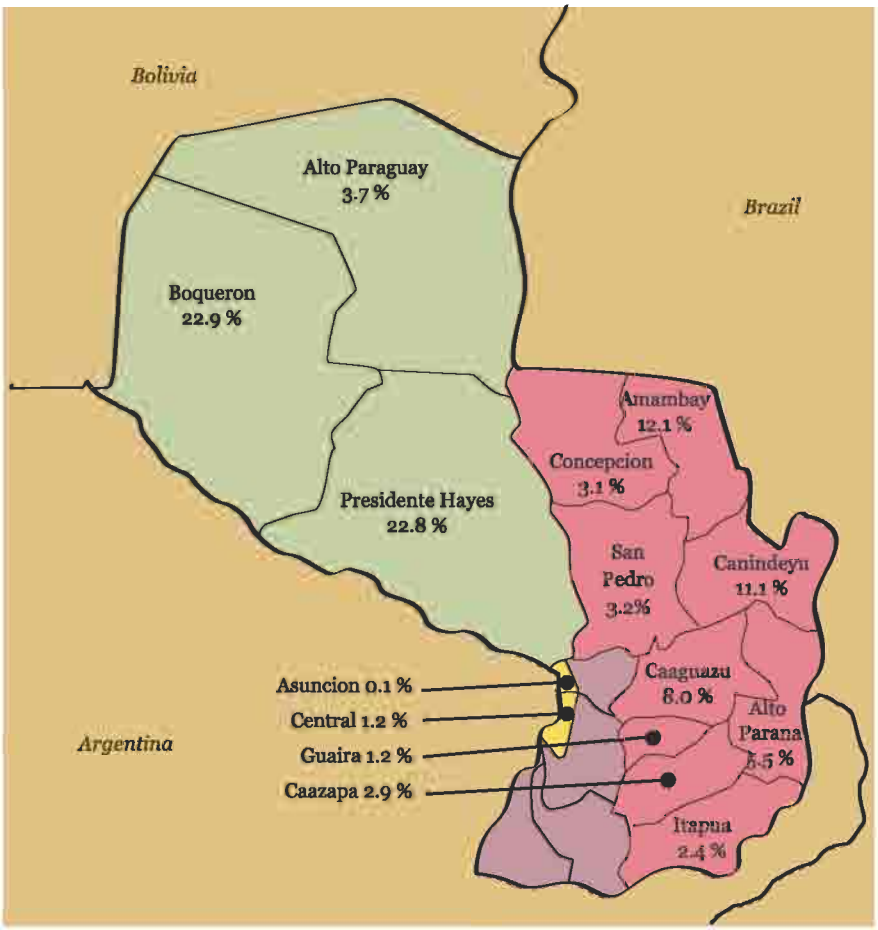
> **Infectious and Contagious diseases:** Indigenous people of the Chaco present the higher percentages of sero prevalence (72-83%). In a recent study of 18 communities, sero prevalence for Chagas ranged between 11 and 78% (ASIS, 2000). Regarding hantavirus in a sampling of 957 samples of 18 communities, prevalence was 15%.

Table 2. Challenges, factors to be considered and inequities (part 2)

In the same study in 1801 serums of the indigenous people were 0,2% positive for hepatitis B while for syphilis it was 7% (Health situation of Indigenous Communities of Paraguayan Chaco 2000). The control program for malaria has made emphasis in the treatment of indigenous population in the departments of Alto Paraná, Caaguazú and Canindeyú because these populations displace all along the frontiers of these departments, dispersing parasites and maintaining an endemic corridor in the zone (SENEPA, 2002).

> **Diabetes, obesity and alcoholism:** In a study of 1720 indigenous of the Chaco it was found a 10% of obesity in this same group, in 1.159 individuals was observed 5,4% cases of diabetes mellitus and 7,2% with altered glucemia in fasting (Health Situation of Indigenous Communities of Paraguayan Chaco, 2000).

Indigenous peoples in **Paraguay**



Suriname

1. International Agreements and National policies. (part 1)

International Agreements	Legal Framework		Technical Units responsible for the health of indigenous Peoples	
	Constitution/ National Policies	Health Policies	Government Bodies/ Ministry	Contact Information
Resolution CD37.R5 Resolution CD40.R6 Beijing Plan of Action Convention on the Elimination of all forms of Discrimination against Women -art. 14- (since 1 March 1993) [49] International Convention on Population Development **Human Rights treaties:** The United Covenant on Civil and Political Rights - art.1 en art. 27- (since December 1976) The International Covenant on Economic, Social and Cultural Rights -art. 1- (since December 1976)	> The legal framework safeguards basic principles. Equity has been defined in the Constitution, art. 8: "No one can be discriminated on basis of sex, ethnicity, religion, education, political preference or economic status". This is in line with the International Convention on Human Rights. > **Constitution, article 36:** "Everyone has the right to health". > The Surinamese Constitution of 1987 provides that ratified international treaties 'which may be directly applicable to anyone shall have this binding effect as from the time of publication' (art. 105), and, that international instruments which are directly applicable shall supercede conflicting national laws (art. 106) > However. art. 137 provide that judges, in a specific case, may declare the application of his law would violate one of the rights enumerated in chapter V of the constitution.	> **Policy Document 2000 – 2005 Ministry of Health:** Improvement of the provisions of primary Health Care to secure better availability to children and women as well as the Peoples in the hinterland. The document also mentions the setting up and implementation of a rational social policy and protection of the most vulnerable groups in the society. > National Health Sector Reform Plan, 2004. > Policy Document Medical Mission, 2000 – 2005.	> Ministry of Health: National policy on health and make health care available to all. > Bureau of Public Health: Public health and preventive health care: Immunization, vector borne diseases, etc. > Regional Health Services: Provides primary health care in coastal area. > Medical Mission: NGO, mandated by Ministry of Health to provide comprehensive health care to the population in the hinterland.	> The Director of Health Dr. R. Codfried Kranenburg H. Arronstraat 64, Paramaribo Tel.(597)477601 E-mail: vogez@sr.net > Dr. L. Resida Bureau of Public Health Rode Kruislaan 17 Tel: (597)497978 E-mail: bogsur@sr.net > Dr. M. Ashim-Sardjoe Director J. Pengelstraat 188 Tel: (597) 400771 E-mail: dirrgd@sr.net > Dr. E. van Eer Director Zonnebloemstraat Nr. 45 Tel (597) 499644 E-mail: info@medischezending.sr

The International Covenant on Economic, Social and Cultural Rights -art. 1- (since December 1976) The International Covenant on the elimination of all Forms of Racial Discrimination -art. 5(d)V- (since March 1984) Convention on the Rights of the Child - art. 2, 3, 6, 8, 12, 17.d., 20, 29, 30 (1993) The American Declaration on the Rights and Duties of Man The American Convention on Human Rights -art. 1, 2, 8, 13, 23, 25- (since 1987) Additional Protocol to the American Convention of Human Rights in the Area of Economic Social and Cultural Rights Protocol of San Salvador- (since 1990).	> **Multi-Annual Development Programme Suriname, 2000 – 2005** Multi-Annual Development Programme Suriname, 2000 – 2005Social security: all registered inhabitants of the interior are eligible for free medical and social services. > The status of the Indigenous Peoples as a separate group is recognized in policy notes, the terms of reference of the Ministry of Regional Development and the Peace Treaties between the Government and the tribal and Indigenous Peoples, throughout the history of Suriname.		

Note: Suriname developed a detailed document on the evaluation of the Decade. This document is in the Health of the Indigenous Peoples of the Ameritas Program's files at PAHO.
[49]CEDAW: article 14 refers to rural women. They mean Indigenous Women as well. We plead for mentioning the Indigenous Women explicitly in article 14.

1. International Agreements and National policies.(part 2)

International Agreements	Legal Framework		Technical Units responsible for the health of indigenous Peoples	
	Constitution/ National Policies	Health Policies	Government Bodies/ Ministry	Contact Information
The Inter-American Convention of the Prevention, Punishment and Eradication of Violence against Women -Convention of Belem do Para- (since 2001). Rio Declaration on Environment and Development - princ. 10 and princ. 22- (1992).				

Notes:

1. The WHO constitution recognizes the right to health as a fundamental human right, and focuses on vulnerable countries and population groups as an integral part of its activities. In May 1998, a resolution on the health of the Indigenous Peoples was passed at the 51st World Health Organization that required the organization to increase its attention to the health needs of Indigenous PEoples in a comprehensive and systematic way, as a contribution to the Decade. In the region of the Americas where PAHO has been active on Indigenous health issues, PAHO adopted the Health of Indigenous Peoples Initiative in 1993 whose principles were reaffirmed in June 1997. The principle, which include a recognition of the need for a holistic approach to health, the right of self-determination, the importance of systematic participation, respect for the Indigenous cultures and reciprocity in relations, served as the basis of a Plan of Action for the region.
2. The Indigenous and Tribal Peoples Convention has been taken into consideration by the competent authorities in 1991, however, the advice was not to ratify the convention since the government is not able to fully commit to this convention. There is need for research, consultations, and compromise on specific sections of the Convention, as the government foresees problems implementing them. More specific and concrete measures should be taken to preserve the traditional lifestyle of the tribal and Indigenous Peoples. The reality is that the Indigenous and tribal communities are situated in the areas where the highest concentrations of Suriname's natural resources are. Ratification of the Convention 169 will not be without consequences, for there will be conflict in the interpretation of rights on land and other rights.

2. Strategic Partnerships and networks of interinstitutional and intersectoral collaboration

Agreements	> Council for the Development of the Interior: (Raad voor Ontwikkeling van het Binnenland) Advisory body to the Indigenous Peoples and the Government. Established as a result of the Peace Accords of 1992. Indigenous members: > Sanomaro Esa: Network of Indigenous Women Organizations, Miss. H. Vreedzaam > Association of Indigenous Village Leaders in Suriname (VIDS), Mr. R. Pané e-mail adres vids@sr.net) > Maroon members: Foundation Equalance, Mr . S. Emanuels
National projects, inter-institutional/ inter-sectoral	> Primary Health Care in the Hinterland of Suriname. A project financed by the Islamic Development Bank to support the health system in the interior. Project implemented in close collaboration with Ministry of Regional Development.
Multi-country Projects	> PAHO supported project of International Vaccination Week, to increase vaccination coverage of the difficult to reach people in the hinterland. In 2004 included international collaboration with Guyana and Brazil, focusing on the Peoples in the border areas. > PAHO TCC Project: Strengthening the Expanded Program On Immunization in Suriname and Guyana, also focuses on the improvement of EPI surveillance and vaccination coverage in the populations in the hinterland.
Inter-institutional/inter-sectoral forums	> Platform Women in Development: Cooperates with NGO's to strengthen the position of the women in general and in the hinterland. > Coordinator: Sharda Ganga. projecta@sr.net > Participants of the Network: (Sanomaro Esa, NVB, Stichting Stop Geweld Tegen Vrouwen, Stichting Projecta)
Indigenous organizations that include the approach of the health in its political agendas	> Sanomaro Esa: Network of Indigenous Women organizations. Main objectives: Health and education for Indigenous women and children. > VIDS: Association of Indigenous Village Leaders in Suriname. Main Objectives: Sustainable development of Indigenous Villages and land rights.
Networks	> VIDS as mentioned above. > Sanomaro Esa (as mentioned above). > Platform Women in Development as mentioned above.

3. Primary health care and cultural diversity

Policies that promote the incorporation of the perspectives, medicines, and Indigenous therapies in the National Health Programs.	> The Policy Document of the Ministry of Health (2000 – 2005) mentions as activities to formalize registration of traditional and alternative medicine practitioners. > The "Report of the Chief Medical Officer 2002" includes in it the intention to improve health of the most vulnerable Peoples, including women, children, and the tribal and Indigenous Peoples.
Experiences of harmonization of the Indigenous and conventional health systems	> The Medical Mission is in charge of comprehensive health care in the hinterland. It has signed an MOU with the "Amazone Conservation Trust" (ACT) to promote the incorporation of Indigenous therapies in their activities. This is an initiative (in two Indigenous villages and one Maroon village) between the ACT and the Medical Mission, and not necessarily part of the national health policy. > The Shamans in the traditional clinics are being trained by the local health assistants of the Medical Mission in the diagnosis of malaria through taking blood samples and microscopy. > When the treatment by the Shamans does not result in cure of the disease, they refer the patient to the conventional clinics of the Medical Mission.
Traditional healers' associations	No associations known to exist. However, the ACT is in process of organizing the Shamans (in the south of Suriname) and other activities within the MOU they have signed with the Medical Mission.
Training and human resources development programs (research and fellowships)	The Medical Mission also trains local villagers as Health Assistants who are responsible for the health services in their villages. The Ministry of Health and other related Ministries contribute with facilities, finances, and other resources.

Notes:
Within the Indigenous Peoples the transfer of knowledge and experiences in traditional health continues under the initiatives of the Shamans.
Novices and apprentices are being trained to keep these practices alive. The practice is all about Indigenous knowledge in action. The Shamans and Apprentices Programme is managed entirely by the Indigenous community itself. Cooperation with the Medical Mission is aimed at achieving integration of the two forms of health care.
The support provided by ACT merely facilitates the practice. The knowledge of medical plants and their uses is vested in traditional healers, who have taken it upon themselves to transfer this knowledge to the next generation of both apprentices and novices. This transfer is the programme's most essential component.
Training deals with various subjects: how to recognize plants in the forest, which parts of the plants to use, which plants should be used for which ailments, and how to prepare and apply the medicines. The practice plays a pivotal role in the recovery and conservation of tribal culture. This will help the Indigenous community to deal better with the outside world. The partnership with the Medical Mission will enhance the Indigenous population's awareness that they have a valuable contribution to make, for their own benefit and for that of the outside world. This realization is expected to contribute greatly to self-esteem, which in turn will encourage them to recover and conserve their own culture. Two Trio communities and one Maroon community are pilot sites for a more elaborate plan that would target the interior of Suriname in its entirety.
Besides the Shamans and apprentices programmes, traditional medicine clinics and medical plant gardens in the three pilot communities, workshops are envisioned at all levels: local, national and international.

4. Information, analysis, monitoring, and management

Information on the demographic, socioeconomic and epidemiological profile of the Indigenous Peoples.	> Policy Document Medical Mission, 2000 - 2005 > Report of the Chief Medical Officer 2002 > Causes of Death in Suriname 2001. Bureau of Public Health, 2003 > The Regional Health Services has an information system with the relevant information on their health services in the coastal area and the Indigenous villages in Central Suriname District.
Information systems, monitoring, and evaluation of the health of the Indigenous Peoples includes the variable of ethnic groups	> The Medical Mission has a comprehensive information system on health statistics based on several variables, by village served. > The Regional Health Services has an information system with the relevant information on their health services in the coastal area and the Indigenous villages in Central Suriname District.
Maps of location of the Indigenous people in the countries in accordance with the political division of the country (includes the map in the annex)	The official national map of Suriname does not show all the Indigenous and Maroon villages. There is no political or administrative division of the country to indicate territories of the Indigenous Peoples. The map in annex is only illustrative of the villages of the Indigenous Peoples and Maroons. [3] *(page. 275)*
Characterization of the Indigenous Peoples with regard to its health and living conditions, social organization and systems of beliefs and values that influence the maintenance and restoration of its health.	A comprehensive characterization of the Indigenous Peoples with regard to its health and living conditions, social organization and systems of beliefs and values is included in the report "Best Practices in Intercultural Health" by the Medical Mission, 2004. Please also see: > Shamans and Apprentices programme: "Promotion and Integration of Traditional Medicine" in "best practices using Indigenous Knowledge" – Americas. > Ellen Roos Kambel and Fergus Mac Kay: The Rights of Indigenous Peoples and Maroons in Suriname, IWGIA Document No. 96, Copenhagen 1999
Periodic publications on the health of the Indigenous Peoples	No such publications are reported.
Section on health of the Indigenous Peoples on the web page of the Ministries of Health, PAHO, or other institutions (electronic address)	No such publications are reported.

Source: Ellen-Rose Kambel and Fergus Mac Kay: "De rechten van Inheemse volken en Marrons in Suriname" KITLV Uitgeverij, Leiden 2003

Second part

1. **Which are the most relevant achievements in the health care of the Indigenous peoples in the period 1995-2004?**

> The once award winning satellite health provision system of the Medical Mission was totally destructed during the years of war in the interior. After the war, in 1996 a slow and innervating process of rebuilding from scratch was started. This process is now such that it can be stated that the glory of before the disturbance in the interior is almost reclaimed.
> Specifically targeted health information and education activities have resulted in increased awareness of the Indigenous Peoples and the Maroons, with regard to communicable and non communicable diseases as malaria, STDs' and preventive care, such as those related to vaccination.
> Abolishment of a traditional use in the Saramaka tribe, to prevent STD transmission in the family. (The traditional practice was that the brother of a deceased husband would have sexual intercourse with the widow, to officially end the period of bereavement).
> Improved vaccination program and anti-malaria program.

2. **Which are the priority problems in the health care of the Indigenous peoples of the country in the area national and subnational?**

> The priority problems are almost as the same as on national basis, except for increased incidence of malaria, infectious diseases, diarrhea, and problems with the availability of safe drinking water, in the dry season.
> Provision of health education and information is difficult because of the remote situated villages, the accessibility of the villages and the available means of information dissemination in the villages. Literacy is also of significant concern in this regard.

3. **Which are the aspects to consider in the insertion of the health of the Indigenous peoples as priority in the processes that the country is promoting in the renewal of the Strategy of Primary Care and in the achievement of the Millennium Goals?**

> Increase awareness of the significant groups in the communities as receivers of care, and their involvement in the provision of the care and related information and education activities.
> Make up for the arrears in provision of medical services for the Peoples in the hinterland.

Strategic Analysis	
Strengths: Characteristics specific of the country that would facilitate the actions aimed at the improvement of the health of the Indigenous Peoples.	**Weaknesses:** Negative aspects within the country that would hinder the actions aimed at the improvement of the health of the Indigenous Peoples.
> Implementation of the Health Sector Reform Plan of the Ministry of Health and the Project for Primary Health Centers in the Hinterland of Suriname > This will improve health services to the Indigenous and maroon population in the hinterland of Suriname. > International Human Rights agreements > Traditional life styles of the ITP > Healthy environment	> Lack of financial means > Lack of human resources > National policy does not account for dispersed settlements of the villages > No exact data available of all communities > No laws or regulations to control the quality of health services in the communities > ILO 169 is not ratified > No formal recognition of traditional leadership and healing practices.
Opportunities: Factors that are in the context, and that it is thought that will act in favor of the actions aimed at the improvement of the health of the Indigenous Peoples.	**Threats:** Negative factors that can affect the implementation of actions aimed at the improvement of the health of the Indigenous Peoples.
> Promote hygiene practices > Health education and information > Improvement of living conditions > Ratification of ILO 169 > Recognition and acceptation of (the values of) traditional knowledge > Participation of IP (in decision making bodies) > Concluding observations of the Committee on the Elimination of Racial Discrimination > (Consideration of reports submitted by states parties under article 9 of the convention. 23 February – 12 March 2004/ 64 session)	> Contamination of the rivers (gold miners) and the spread of infectious diseases > Not aware of the new/emerging threats to their health > Ignoring the traditional life styles of the IP (in the constitution) > Lack of legal protective measures with respect to human rights, land rights, culture and Indigenous costumes and traditional knowledge. > Unregulated use of Indigenous traditional knowledge > Western oriented economic development > International/multilateral agreements such as FTAA and TRIP.

Third part

Table 1. Population and Indigenous Peoples of Suriname (population expressed in thousands of inhabitants) (1999)

National	Indigenous Peoples	Percent	Maroons	Percent	Indigenous and Maroons	Percent
460,000	10,000 -22,000	2.5% - 6%	40,000 -45,000	8.5% - 10 %	60.000	13 %

Source: Ellen Roos Kambel and Fergus Mac Kay: The Rights of Indigenous Peoples and Maroons in Suriname, IWGIA Document No. 96, Copenhagen 1999

Table 2. Challenges, factors to consider, and inequities (part 1)

Challenges

Strategies of health and public health should include and address the structural factors of risk and to be inserted in the strengths of the Indigenous Peoples:

- Holistic vision of the wellbeing of the individual, of the family, the community, and environment.
- Cultural capacities, linguistic, organizational, of negotiation and leadership.
- At the beginning community adherence of reciprocity, solidarity and respect and ancestral knowledge.

Perhaps the major challenge in provision of health and related services, including education, is the fact that the majority of the Maroon and Indigenous Peoples live in locations which are very difficult to access. The main routes of transportation are the rivers, along which the majority of the villages are situated, and by air. There are some airstrips in the vicinity of the villages.
The transportation by boat can take several days to reach a village, depending on the water level in the rivers. Transportation by air is only possible through chartered flights, which is very expensive for the villages to call upon.
The several tribal languages that these peoples speak is another issue to be considered.

Factors to consider

- **Location:** The Indigenous population, in general is scattered, in some cases mobile remote and for the most part localized in rural areas, urban fringe, and border. This makes it very difficult to reach the villages and for the provision of social services including medical care.
- The delivery of adequate services is a complex matter depending on several factors that are not functioning adequately: infrastructure, limited means of transportation, water and electricity, communication means, limited development and education opportunities, employment, etc.
- Health workers and educators are difficult to find for the interior because of the hardship to endure and inadequate or insufficient facilities (clinics, schools, etc.).
- The Bush Negroes and Amerindians are semi sedentary population: They are used to settle in villages or "camps". But the population is moving regularly. The need of new heap of felled trees, some big feasts of the community or a new marriage are some of the reason why they move.
- The migration of the population is an important factor to take in consideration. This is not an issue as regards the Indigenous Peoples. Only the Trio and the Wayana villages are returning to their former bases at this moment. Sometimes the villagers themselves visit their relatives in other villages, sometimes in Brazil, for a short or longer period. Also the ITP's of east and west Suriname visits their relatives in the neighbouring countries, resp. French Guyana and Guyana.

Table 2. Challenges, factors to consider, and inequities (part 2)

> **Ethnic and cultural heterogeneity** The Indigenous Peoples are estimated in about 20.000 people, belonging to nearly 4 Peoples that speak 4 tongues.
The Maroons are estimated in 45.000 people, belonging to 6 tribes that speak 6 tongues.

> **Culturally appropriate care:** Both the Indigenous Peoples as well as the Maroons continue providing traditional care, according to their cultures and beliefs, to their respective Peoples (even when these are admitted in the hospital). These traditional services are for them the first option when needed. These services exist next to the formal health services provided by the Medical Mission and the Regional Health Services.

Inequities

> **Poverty:** It is generally accepted that the Peoples of the Indigenous villages are living under extreme difficult situations and that they are categorized as "poor".
Most villages lack basic facilities, mainly because of the difficulty of accessibility.
Poverty is lowest in the urban stratum with approximately 52% of the households living below the poverty line. For the rural stratum this is 61% and for the interior the proportion below the poverty line is 91%.
One should be cautious with comparisons between the interior and the urban or rural strata, as this poverty assessment is based on a uni-dimensional index with income and the price of a basic food basket as the principal dimension. However, in the interior many communities depend on subsistence farming for food intake, rather than earning exclusively a money income. Therefore the income poverty measure could overestimate the proportion of households in the interior that live below the poverty line.

> **Literacy:**
There are no exact figures known of the literacy rate of the ITP's. There are large variations according to region ranging from 4.3% of children in the interior to 51.6% in the urban, attending kindergarten or community childcare.
School attendance in the interior (61.2%) is significant lower than in the rest of the country (78%). At the national level, there is virtually no difference between male and female school attendance.
Almost 84% of children who enter the first grade of primary school eventually reach grade 5. Only 84.8% of children in the interior entering grade 1 reach grade 2, compared to 100% of children in the urban areas and 96.6% in the rural areas. Overall, only 64.5% of children in the interior who enter grade 1 reach grade 5 in comparison to 92.8% of those n urban areas and 82.5% in rural areas.
Overall literacy of the population aged 15 years and older is 86.2%. Overall literacy in the interior is far lower by 51.1%.

> **Unemployment:** Unemployment among the ITP's is very high. Most villagers are engaged in agriculture mostly for own consumption. There are no detail figures available for this indicator.

> **Basic services:** Most villages have no running water or electricity. Approximately 73 percent of the population has access to safe drinking water: 92.6% in urban areas and 66.6% in rural areas. The situation in the interior is considerably worse than in the other regions: only 20% of the population in this region gets its drinking water from a safe source. Eighty percent of the population in Suriname is living in households with sanitary means of excreta disposal. There are vast differences between the urban and rural regions with over 98% and the interior by 30.5% having sanitary means of excreta disposal. Most of this population, about 68%, has no access to sanitary facilities and uses rivers, bush and or fields. Some villages that have a power generator are strongly dependent on the supply of fuel. The majority uses oil lamp. Almost all villages depend for their water supply on the river water, creek, well, or rainwater.

Table 2. Challenges, factors to consider, and inequities (part 3)

> **Infant mortality:** The IMR among the Indigenous and maroon children is not significantly higher than that in the city. Official figures could not be obtained. It is estimated that the infant mortality rate on national level is 29 per 1,000 and 37 per 1,000 for the under-five mortality rate (1998).

> **Maternal Mortality:** The maternal mortality rate is not significantly higher than in the city. Official figures could not be obtained.

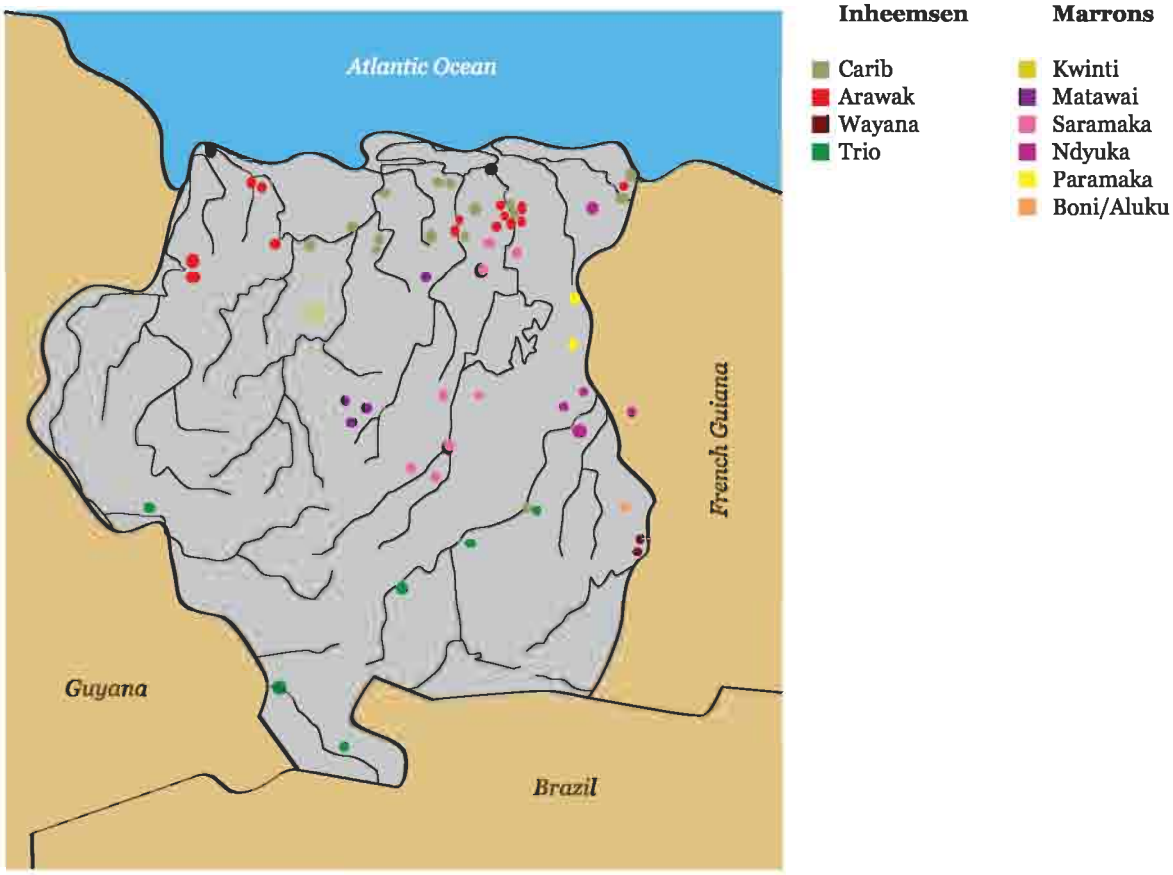
> **Malnutrition:** Chronic malnutrition is high among the Indigenous population. Official figures could not be obtained. Slightly over 13% of children under five in Suriname are underweight or too thin for their age and 2.1% are severely underweight. Approximately 10% of children are stunted or too short for their age and 6.5% are wasted or too thin for their height. Children whose mothers have secondary or higher education are the least likely to be underweight and stunted, compared to children of mothers with less education.

> **Infectious diseases:** Malaria is endemic in the interior. The interior of Suriname has the highest level of malaria risk: 72.2% of under five children slept under a bed net. Only about 5% of the bed nets used is impregnated with insecticide. Some figures are provided in the "Observation" section of the detailed documento.

> **Diabetes, Obesity, Alcoholism:** Official figures could not be obtained. Some figures are provided in the "Observation" section.

> **Suicide:** Official figures could not be obtained. There is no indication that the suicide rate is higher under the Indigenous Peoples.

Indigenous peoples in **Suriname**



Observations

> Indigenous people are the descendents of the original inhabitants of a geographic region, prior to colonization, who have maintained some or all of their linguistic, cultural and organizational characteristics. Although the descendents of the runaway slaves that live in tribal communities in the interior of Suriname also maintained some of their African linguistic, cultural and organizational characteristics, they are not descendents of original inhabitants and therefore are not considered Indigenous Peoples in Suriname.

> The Amerindian tribes are the original inhabitants of the Guyana's. The Indigenous and tribal Peoples in Suriname have contact with urban civilization and rely in part on supplies from the city and from NGO's and facilities provided by the government regarding education and health.

> For years, the Indigenous Peoples and Maroons have migrated to the city. In 1986 a civil war in Suriname urged large numbers of tribal and Indigenous people to evacuate their villages and seek refuge in Paramaribo and French Guyana. The civil war caused much destruction to the villages and the infrastructure in the interior. The rehabilitation process of the villages is still not in full progress. Many areas are still without adequate infrastructure and facilities.

> A large part of the tribal people never returned to their villages and stayed in the city and in French Guyana because of practical needs, better living conditions ad facilities. Even a whole generation was born in Paramaribo and French Guyana that is not familiar with the way of life in the interior. The VIDS (Association of Indigenous Village Leaders in Suriname) has registered about 37 Indigenous villages in Suriname.

> The responsibility for social security lies with the Ministry of Social Affairs and Housing. The Ministry has the task to set up a national social security scheme, which momentarily does not exist. Regarding the aspect of Health, the Ministry of Health states that the infrastructure to facilitate the communities already exists and is functioning. The Indigenous and tribal people have access to free medical aid; the medical facilities in the interior are adjusted to the needs of the communities and services are provided by local community health workers. However, the Government of Suriname does not legally recognize the traditional preventive care healing practices and medicines.

> According to the Constitution of Suriname, article 41: "Natural riches and resources are the property of the nation and shall be used to promote economic social and cultural development. The nation shall have the alienable right to take complete possession of the natural resources in order to apply them to the needs of the economic, social and cultural development of Suriname". This article indicates that the Indigenous Peoples have no say in policy and decision-making regarding the exploitation of natural resources in the territories they occupy.

> Convention 169 is considered a good guide to promote the living conditions of the Indigenous and tribal Peoples (ITP's), taking into account conservation of their traditional lifestyles, traditions and customs. However, there is a need for research, consultation and compromise regarding certain sections of the Convention as the Government foresees problems implementing them. Nonetheless, the government considers that Indigenous Peoples and Maroons require special attention and is therefore committed to improving their current status. It will consider the Convention in its policy and decision making with regard to the development of the interior and matters concerning ITP's. [50]

[50] Report of the National Workshop on the ILO's Indigenous and Tribal Peoples Convention, 1989 (no. 169). Paramaribo, 7 – 8 October 2003.

Venezuela

1. International Agreements and National policies. (part 1)

International Agreements	Legal Framework		Technical Units responsible for the health of Indigenous Peoples	
	Constitution/ National Policies	Health Policies	Government Bodies/ Ministry	Contact Information
Agreement 169 ILO, Resolution CD37.R5, Resolution CD40.R6 Promotes commitment of government with indigenous people. It includes themes referring to: self determination of indigenous people, culture, land, natural resources, work condition, professional training education and environment. **Agreement on Biologic Diversity.** (1992) **Agreement for the Constitution of the Fund for Development of Indigenous People of Latin America and the Caribbean** (July 1992).	**1999.** Constitution of the Bolivarian Republic of Venezuela (CRBV) defines the republic as a democratic, participatory, multi ethnic and pluri cultural society. *Article 9*: "Official language is Spanish. Indigenous languages are official languages for indigenous people and should be respected in the republic as they constitute cultural heritage of the nation and the humanity" *Article 23:* Establishes that treaties, covenants and conventions relative to human rights subscribed and ratified by Venezuela, have constitutional hierarchy. *Article 83:* Establishes that health is a fundamental social right and that the State will guarantee as part of the right to life. *Article 100:* Popular cultures that constitute Venezuelan heritage, have a special attention and the inter culturality is recognized and respected under the principle of equal cultures. *Article 119:* "The state will recognize the existence of indigenous people and communities, their social, political and economic organization, their culture, use and custom, languages and religions as well as their habitat and original rights on land ancestrally and traditionally occupied and that are needed to develop and guarantee their ways of life"	**Decree 1795** (May 2002): Provides the obligatory use of indigenous languages in indigenous habitats as well as in other rural and urban zones in which indigenous live. **Misión Barrio Adentro** Health Policy to widen coverage with direct participation of communities. It tries to integrate all social policies through the creation of health, food, social economy, popular cultural and communication education, sports and recreation; develop programs of integral attention, contribute with the work of community organization among others. **In the National Assembly,** three indigenous members or their alternates participate. At the level of states with indigenous population there is the participation of a member and the corresponding alternate. **Decree 1796** (Mayo 2002): UIT this decree created the National Education, Culture and Indigenous Languages Council; this is an advisory body of the national executive with permanent character for consultation of policies of indigenous communities in the historic, cultural and linguistic scope.	› Health and Social Development Ministry (MSDS). General Direction of Indigenous Health (in process of definition and structure).	› Dr. Noly Fernández, Coordinadora de Salud Indígena

Andean Community of Nations: Andean Letter for Promotion and Protection of Human Rights, Part VIII referred to indigenous people and community of afro descendants (Julio 2001).	***Article 120:*** establishes the use of natural resources in indigenous habitats without damaging the cultural social and economic integrity in addition to previous consultation to this population. ***Article 121:*** establishes the right of indigenous people to maintain and develop their ethnic and cultural identity , Cosmo vision, values, spirituality and their sacred places and cult. ***Article 122:*** "Indigenous people are entitled to integral health that considers its practices and cultures. The state will recognize their traditional medicine and complementary therapies subject to bio ethic principles." ***Article 123:*** establishes the right to their own traditional economic practices and the right of workers and indigenous workers. ***Article 124:*** establishes the protection to collective intellectual property of indigenous people and forbids the registry of patents on ancestral knowledge. ***Article 125:*** Establishes the right to political participation of indigenous people and guarantees its representation in National Assembly. ***Article 126:*** Establishes that the indigenous people and communities belong to the nation, state and people of Venezuela and that they have the obligation to safeguard national integrity and sovereignty.	The Commission was created for demarcation of land and Habitat of Indigenous People. The Permanent Commission of Indigenous People and communities regarding the Project of Organic Law of Indigenous People and Communities was created; It has designed this Project with participation of indigenous people and it is in charge of follow up until approval.	

1. International Agreements and National policies. (part 1)

International Agreements	Legal Framework		Technical Units responsible for the health of indigenous Peoples	
	Constitution/ National Policies	Health Policies	Government Bodies/ Ministry	Contact Information
	Article 169: establishes that the legislation regarding municipal and other entities take into consideration the organization of the government regime and local administration that corresponds to municipal with indigenous population. ***Article 181:*** Establishes that indigenous land is not considered common land. ***Article 186:*** Establishes the election to National Assembly of three indigenous members as established in the Election Law. ***Article 260:*** Establishes that legitimate authorities of indigenous people can provide justice in their habitat on basis of their ancestral traditions and that it only affects their members if and when this does not contradicts the Constitution, Law and Public Order. ***Article 327:*** Establishes priority in attention of frontiers protecting expressly the habitat of indigenous people among other things. ***Law for Demarcation and Guarantee of Habitat and Lands of Indigenous People.*** (January 2001) ***Bill of Organic Law of Indigenous People and Communities LOPCI.*** (December 2001). First Organic Law on indigenous people and communities in the legal history of the country.			

Bill of Education Law of Indigenous People and use of their language.

Project of Organic Health Law and Public National Health System Has the purpose of improving health condition of the population with emphasis on most vulnerable groups that allow excluded majority the claiming of their social rights among them the right for health as fundamental social right to improve quality of life of the population.
Article 60, paragraph 13: Indigenous people are entitled to the use of their medicine and traditional health practices as part of health prevention and restitution including the protection of plants animals and minerals used for this purpose.
Article 105: UIT the purpose of strengthening national capacity in the scope of complementary therapies will be created the National Commission of Complementary Therapies to advise the Ministry with competent in Health on this regard. The commission will be ruled by the corresponding regulation.
Article 106: the ministry with competence in health will design and execute, with participation of indigenous representatives a special health plan directed to those ethnics under serious risk of biologic extinction or irreversible demographic decrease and will maintain a special system of follow up of their health conditions.

2. Strategic Alliances and inter institutional and inter sectional networks of cooperation (part 1)

Agreements	
Inter institutional/ inter sectorial Projects	> **Projects with bodies attached to MSDS** > **National Autonomous Services for Integral Attention to Infants and Family (SENIFA).** Daily Care where attention, care and food are provided to indigenous children. : 253 Homes and Multihomes have been organized in indigenous communities They attend 8.898 indigenous children in 6 of the 8 states with indigenous population. > **National Institute of Nutrition (INN):** Program Community Kitchens: Implements actions to reach food safety for the Venezuelan population, especially for most of the vulnerable groups. It consists of developing a communitary house or place in the indigenous people's communities living in extreme poverty. Then, the people who live here would get involved to be responsible for the communitary canteen, with the support of other members of the community, city halls and INN. There are 46 community kitchens in four states with indigenous population benefiting a population of 4.810. > **Fund of Social Investment of Venezuela (FONVIS):** Finances and executes projects designed by the communities under the supervision of Technicians of FONVIS. > **Amazon Center for Research and Control of Tropical Diseases (CAICET).** Develops research activities and control of tropical diseases in Amazonas state which has 19 indigenous people. > **Coordination of Provision of Health Services:** Unit of Medical Attention; Laboratory Unit of Diagnosis. > Tuberculosis unit with research activities and health actions. > Malaria unity with research activities and health actions. > Intestinal parasitoids unit with research activities and health actions. > Emergent and re emergent disease Unit with research activities and health actions. > Research on oncocercosis: with research activities and health actions. > Oncocercosis Unit with research activities and health actions. > **Civil Society for control of Endemic Diseases and Sanitary Assistance to Indigenous (CENASAI):** develops two projects in Bolivar state that has 17 indigenous people. . > **ATSAI project:** medical and dentistry attention is provided to indigenous communities located in areas of difficult access. > **SILOSAI Project:** through this Project, a local health system has been created in the indigenous area with participation of 610 communities attended by CENASAI. > **Inter institutional inter sector Projects** *Guaicaipuro Mission:* > Attention to indigenous students:

Inter institutional/ inter sectorial Projects	> Up to now, 203 indigenous graduates from high school have benefited from the scholarship program of the Ministry of Higher Education and National Institute of Youth. > Currently 3182 indigenous students are attending university in the Bolivarian University of Venezuela (UBV), National Experimental University of Armed Forces (UNEFA), Los Andes University (ULA), Central University of Venezuela (UCV). > There is a project for the construction of an Indigenous Center that will operate in Caracas and will allow attention to 462 students in its first stage, and 830 in the second one. > The regional organizations postulated ten youngsters that will continue higher studies in Mexico. The Guaicaipuro Mission supports by holding journeys corresponding to registry, the legalization, obtaining of passports and strengthening of education matters along with other organizations. > Enhancement of demarcation process: > In Sucre, Zulia, Amazonas, Monagas, Apure, Bolívar and Delta Amacuro States, was held the workshop for GPS operation and Reading and Interpretation of Maps in coordination with IGVSB, which had great acceptance from participant communities. > In 2004 the goal was to train 440 indigenous representatives. They were trained in two stages: an event held in > Caracas trained 204 representatives and events held in the status allowed training of 210 indigenous representatives at national level. > 09 files and approximately 20 requests for demarcation have been recently incorporated to the National Demarcation Commission. The total files currently managed by the commission are 40. > Attention to indigenous homeless: > Regarding indigenous homeless, the Foundation Proyecto País approved the economic help corresponding to the purchase of materials and equipment to be used in the clearing and preparation of the tract of land where 531 homeless indigenous have been relocated in Caracas and Barrancas del Orinoco Malecon Zone. > The mayoralty of Sotillo's municipality cleared 90 hectares for the Project which is the basis of the advance of an endogenous development nucleus starting with the local council of public planning. > The Equipment and material will soon be delivered to the communities, activity coordinated by Guaicaipuro Mission and Foundation Proyecto País. **General Direction of Indigenous Matters of the Education and Culture Ministry** > Health Unit: Develops the project "Towards the design of Intercultural Health Policy". Several workshops have been held in the states with indigenous population on the updating of simplified medicine and the incorporation of indigenous traditional medicine. > Workshops about community health agents, the induction workshops for the production of texts, images and other didactic resources referring to indigenous health. . **Foundation Proyecto País of the Unified Body of National Armed Forces** *Plan Bolívar 2000*. Armed Forces held journeys of medical surgical attention,

2. Strategic Alliances and inter institutional and inter sectional networks of cooperation (part 2)

Inter institutional/ inter sectorial Projects	vaccination, dentistry, rehabilitation of health establishments among other activities. » *Direction of National Development.* » *Indigenous Matters* entity created by the National Guard for the attention of indigenous population. » *Support of International Bodies* » *International Red Cross, Spain,* is developing an integral health Project in Delta Amacuro state with the warao indigenous population of Antonio Dias municipality (10 communities).
Multi-country Projects.	
Inter institutional / inter sectorial Fora.	
Indigenous organizations which include health care/approach in their political agendas.	
Networks	

3. Primary health care and inter culturality

Policies that promote indigenous perspectives, medicines and therapies in National Health Programs	References made in the section on "International Agreements and National Policies".
Harmonization experiences of indigenous and conventional health systems.	*Amazonas State:* In Puerto Ayacucho (capital), the Specialty Center "Gilberto Rodríguez Ochoa" was installed, belonging to the governors office where medical attention is provided (pediatrics, gineco obstetrics, general surgery and internal medicine resides homeopathy, acupuncture and attention by shamans. *Zulia State:* Wapulee are intercultural community spaces for education and health of Wayuu indigenous- These centers are oriented to strengthen and recreate traditional Wayuu collective spaces and its pedagogic capacity to provide attention and support in health and education of Wayuu families particularly children up to 6 years old.
Associations of indigenous therapists.	
Programs of training and development of human resources (research and scholarships).	> Central University of Venezuela (UCV) has entered several agreements in the Amazonas and Delta Amacuro Status through which this university sends students of the last year (trainees) in medicine, dentistry, nutrition, nursing among other during two months to work with indigenous population. > Agreement of the government of Zulia state with the University of Zulia through which it is established that 10% of the registration quota should be used by the population of rural areas including the indigenous people. > Cuba / Venezuela Agreement: trains Venezuelan youngsters including indigenous in the Latin American University of Medical Sciences of La Habana, in the Social Work School, in Sports, among others. > Training of indigenous and non indigenous Venezuelan doctors in Integral General Medicine in Venezuela in the Barrio Adentro Mission.

4. Information, analysis, monitoring and management

Information about demographic, socioeconomic and epidemiologic profile of the Indigenous people.	Socio demographic characteristics of indigenous population appear in INE with data of Indigenous Census 2001. www.ine.gov.ve
Information, monitoring, evaluation systems of health of indigenous people. It includes the ethnic variable.	In the Ministry of Health and Social Development (MSDS), it has not been possible to identify the population by their ethnic condition and thus it is difficult up to this date to establish their situation, coverage degree and other data.
Localization maps of indigenous people inside the countries according to its political division. (Include the map in annex).	There are currently maps with ethnic location and distribution of each indigenous people. National Institute of Statistics (INE), Indigenous Census 2001. (page 294)
Characterization of indigenous people in respect to their living and health conditions, social organizations as well as maintenance and recuperation of their health.	
Periodical publications about health conditions of indigenous people	MSDS has a Web page and it is constructing a specific section on indigenous health.
Section about the health conditions of indigenous people in the Web page of the Ministries of Health, PAHO or other institutions (e-mail address).	

Second part

1. What are the most relevant achievements concerning health of indigenous peoples during the period 1995-2004?

> In 1999, the Constitution of the Bolivarian Republic of Venezuela is born with the participation of the Venezuelan people, including indigenous people and communities in which an exclusive chapter has been assigned to the rights of indigenous people. (Chapter VIII).

> Ministry of Health and Social Development creates a work team with anthropologists and doctors to attend the indigenous population, especially in the states where this population is more depressed and numerous (2003).

> The National Executive assigns extraordinary resources to indigenous people and communities for their health care. (2002).

> The Ministry of Health and Social Development creates Intercultural Health Coordination with Indigenous People (2004).

> Training in Medicine and Social Work of indigenous high school graduates in Cuba through the Cuba / Venezuela Agreement for this purpose.

2. What are the priority issues regarding assistance to indigenous people health during the period 1995-2004?

> Inequity in the distribution of resources directed to the attention of health problems in indigenous population.
> Inequality in access and use of health services: the socio economic level and geographical accessibility have considerable incidence.
> Fragmented use of human and financial resources assigned to sectorial and extra sectorial plans and programs destined to the improvement of health conditions of indigenous people.
> Definition of a work scheme involving indigenous knowledge and Cosmo Vision in interaction with health systems.

3. What are the aspects to be inserted into indigenous people's health as part of the priorities in the processes the country is promoting for the renewal of the Primary Care Strategy and the fulfillment of Millennium Goals?

> Recognition of cultural diversity as a paradigm for the construction of an integral health model with emphasis in the articulation between traditional and western medicine.
> Protection of ecologic biodiversity in territories of indigenous people, as natural resources are affected by activities and development projects that endanger the health of the communities and population in general.
> The construction of new institutionalism and inter sectors as paradigm for integral work that provides answers to health needs of the population.
> Design of strategies that enable the obtaining of information of systematic basis and coordinated on life condition and health situation of indigenous people.
> Favor principally the participation of indigenous people and communities in the identification of problems and in the generation, management, follow up, and evaluation of local projects and experiences that contribute to improve accessibility, quality, and equity of sanitary attention.
> Unawareness of health statistics of indigenous population.

Strategic analysis	
Strengths: particular characteristics of the country which would facilitate actions towards the improvement of indigenous people health.	**Weaknesses:** inner negative aspects of the country which would difficult the actions towards the improvement of the indigenous peoples health.
> The Constitution recognizes the right of indigenous people and communities. > Progressive development of initiatives that promote the self management capacity of the communities and concentration of efforts through local governments (state and municipal). > Political agreements between National Government and most of the governors offices of the states, majors of municipalities with indigenous population as well as indigenous organizations.	> Inequity in the assignment of resources without explicit criteria and thus with no specific indicators. > Lack of inter cultural training of human resources. > Coexistence of perspectives: assistentialism vs self management; integration versus inter culturality. > The Inter Cultural Health coordination with Indigenous People (CISPI), still lacks sufficient management capacity to attend health demands of this population as it has been recently created and the great expectancies of these people were recently taken into account. > Lack of intercultural vision, sensitivity and knowledge on life conditions, cosmovision uses and customs of indigenous people in the government institutions.
Opportunities: factors in context believed to act in favor of actions aimed at improving health of the indigenous people.	**Threats:** negative factors that may affect the implementation of actions aimed at improving health of the indigenous people.
> Conformation of Intercultural Health Coordination with Indigenous People in the Ministry of Health and Social Development. The purpose is to promote and coordinate with other direction offices and institutions of the MSDS and similar institutions with plans and programs addressed to indigenous population. > Creation of Guaicaipuro Mission to restore the rights of indigenous people through inter-sectorial coordination of different ministries and government and nongovernmental organisms.	> Preexistence of power and authority systems. > Complexity of internal relations of indigenous communities and organizations. > Interests causing corruption, non operation, and bureaucracy in governmental institutions.

Strategic analysis	
> Constitutional presence of representatives of indigenous people in the National Assembly and state and municipal legislative organisms. > Creation of the Permanent Commission of the Indigenous People of National Assembly with the purpose of generating and promoting laws and initiatives in indigenous matters (2000). > Construction of strategic alliances to support work on agreed solutions for health condition improvement of the indigenous people.	

Third part

Table 1. Population and indigenous peoples of Venezuela

National Population	Number of indigenous communities	indigenous communities Population	Urban areas population	Country indigenous population	%	Peoples
	1.889	183.343	350.348	533.691		36

Source: INE, Census of Indigenous Communities 2001.

Table 2. Challenges, factors to be considered and inequities (part 1)

Challenges

Health strategies and public health should encompass and address structural risk factors and become part of the strength of the indigenous people:

- Statistical visibility of indigenous population by considering them a statistical category in census, and permanent administrative registries. This absence does not allow to establishing precisely a current situation and gaps that separate indigenous population from the non indigenous one.
- The mainstreaming of policies and programs directed towards the population in the whole structure of Executive Power.
- Application of ethnic indicators in national social programs making visible indigenous population and orienting social investment towards the most vulnerable segments of population (children, women, elders).

Factors to be considered

- **Localization:** Most of the indigenous communities are located in rural zones, many of them of difficult geographical access and their distribution show high dispersion. Likewise, internal migration process involves displacement of families from their place of origin to cities and periphery, looking for better life conditions that in most cases are not secured.

- **Ethnic and cultural heterogeneicity:** Venezuela is a multi ethnic and pluri cultural country. There are 36 indigenous peoples nationalities mainly located in eight states of the country. Most of the diversity of the indigenous people is located in Amazonas and Bolivar, states located in the southeast part of the country. Most of indigenous people is located in Zulia state placed at the north occident of the country.

- **Culturally appropriate health care:** The attention provided to indigenous people is the same provided to non indigenous population; it means there is no socio cultural pertinence in the attention to indigenous people. With the new Intercultural Health Coordination of Health with Indigenous People (CISPI), actions are being taken to provide a more adequate attention to this population.

Inequities

- **Poverty:** The poverty dimension of indigenous people is not known. There are situations that evidence how critical the situation is for example in large properties; communities that periodically go to big cities where they live in the streets or collecting whatever they need from garbage dumps. Indigenous people are highly vulnerable to diseases and epidemics that cause a high mortality index.

- **Illiteracy:** There is a high illiteracy index and low schooling average. Besides the access coverage and low quality of education problems, those of pedagogic pertaining should be added. Literacy in their own language continues to be deficient. Children and adolescents ignore the origin of their own people and they gradually loose the cultural bases and foundations of their people.

- **Unemployment:** Due to the lack of registry of the indigenous population there is no exact statistics that indicate the employment situation in this population. Economic activities developed by indigenous people are not promoted by current policies in the country and are not recognized enough as part of national economy.
These activities are reduced to seasonal work in the harvest of different products, artisan production, insertion in temporal work plans and informal economy. We should also mention the actions directed towards self consumption production that conform subsistence strategies.

Table 2. Challenges, factors to be considered and inequities (part 2

- **Utilities:** Most of indigenous communities lack of drinking water services, they continue to use water from natural sources; due to development these sources are significantly contaminated which has caused a high index of morbi mortality in this population.

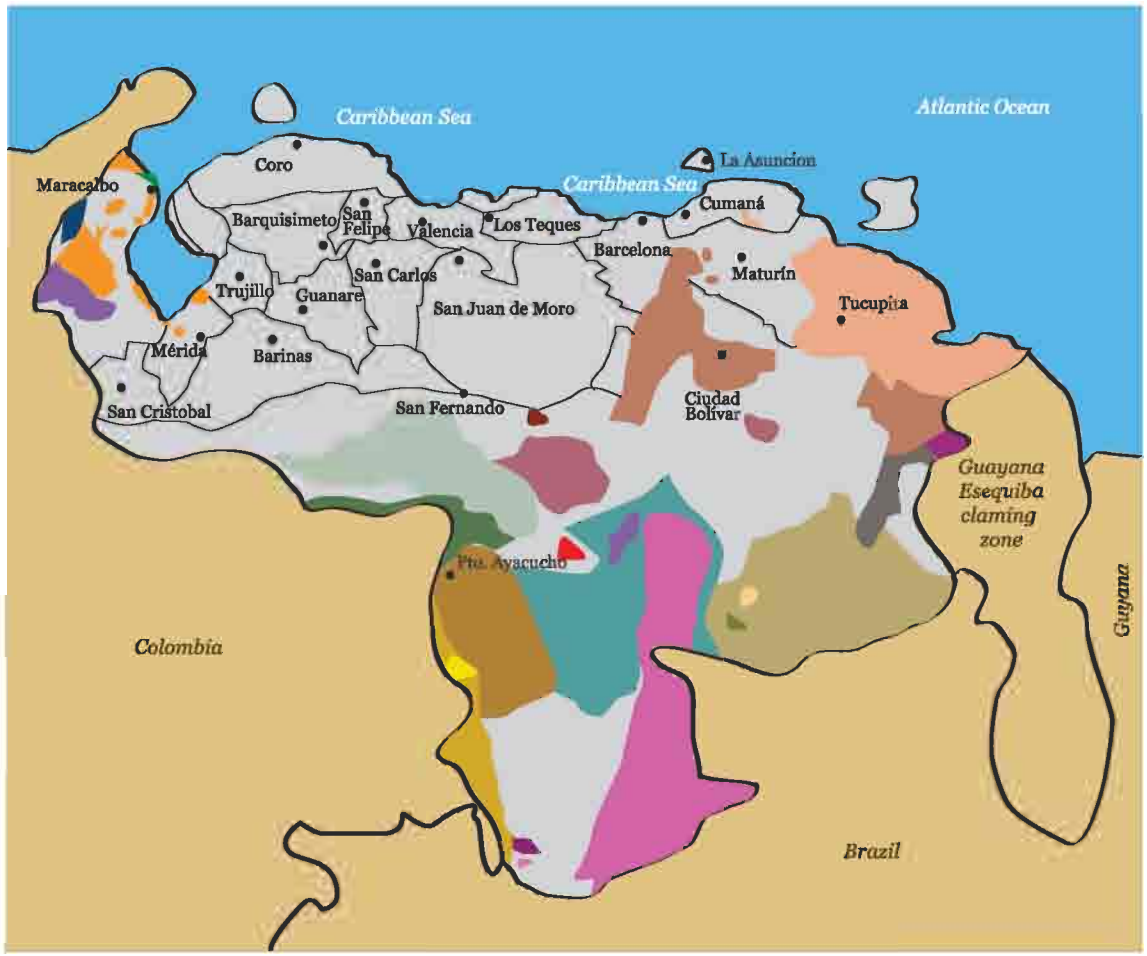
- **Infant Mortality:** Due to the lack of registry of indigenous population it is impossible to establish infant mortality in this population. The 2000 infant mortality done by the municipality, indicates that the municipalities with higher mortality rate are the indigenous ones, the first one is the municipality of Alto Orinoco, in Amazonas State with a rate of infant mortality of 88,4; the following is the Delta Amacuro State , Antonio Díaz municipality with a rate of 51,1 and in the third place the Amazonas, Autana municipality with a rate of infant mortality of 46,81; the first two are located in the worst life conditions strata.

- **Maternal Mortality:** Direct obstetrics causes predominate on maternal mortality. The municipality with the higher maternal mortality registered for 2000 was Almirante Padilla Zulia state with 707; second is Atabapo, Amazonas state with 631 and the third one is Antonio Díaz Delta Amacuro state with 287. These municipalities of high proportion of indigenous population are in the worst life conditions strata.

- **Undernourishment:** Infant undernourishment is the main cause of morbi mortality in indigenous children.

- **Infectious Diseases:** Predomination of intestinal and respiratory diseases, skin and mucose diseases of bacteria, parasite and mycotic origin.

Indigenous peoples in **Venezuela**



Indigenous Peoples of Venezuela

- Akawayo
- Añu
- Arawak del Norte
- Bari
- Eñepa
- Guajibo
- Jodi
- Kariña
- Mapoyo
- Pemon
- Piaroa
- Puinava
- Pume
- Saliva
- Sape
- Uruak
- Warao
- Wayuu
- Yanomami
- Yavarana
- Yekuana
- Yeral
- Yukpa
- Arawak del sur
  (Baniva, Bara, Kurripaco, Piapoko, Warekena)

Annexes

Population and indigenous peoples of the Americas

The next table has been built from various sources and updated with data from each one of the countries' profiles.

Americas Population and indigenous peoples

(Population in thousands of inhabitants)

	Country	National Population	Indigenous Population	%	Peoples #
Proportion	1. Bolivia	8.274	134	62	37
More than 40%	2. Guatemala	11.678	5.004	43	23
	3. Peru	24.797	11.655	47	51
	4. Ecuador	12.175	5.235	43	14
	5. Belice	230	44	19	2
	6. Honduras	6.194	743	12	9
	7. Mexico	105.000	12.400	12	62
	8. El Salvador	6.757	743	11	3
From 5 to 20%	9. Nicaragua	5.407	448	8.3	9
	10. Panama	2.800	232	8	7
	11. Guyana	850	51	6	9
	12. Suriname	460	22	6	6
	13. Chile	15.116	692	4,6	8
From 1 to 4%	14. French Guyana	100	4	4	6
	15. Canada	31.414	976	3	3
	16. Argentina	36.260	1.100	3	25
	17. Colombia	43.000	877	2	82
	18. Venezuela	23.242	533	2	36
	19. Caribbean Islands	8.406	162	2	1
	20. Paraguay	5.163	89	1.7	20
	21. Costa Rica	3.810	63	1.7	8
Less than 1%	22. Brazil	169.799	426	0	210
	23. United States	260.800	1.959	0	166
	24. Uruguay	3.289	1	0	1
	Grand Total	548.606	43.593	14.3	798

Source: IDB, 2002. Country reports on the evaluation of health achievements within the framework of the International Decade of the World's Indigenous Peoples, 2004.

PAHO's Resolutions CD37.R5, CD40.R6, CD47.R18

RESOLUTION CD37.R5 "HEALTH OF THE INDIGENOUS PEOPLES "

The Directing Council,

Having seen Document CD37/20: Initiative on "Health of the Indigenous Peoples of the Americas"; Taking into account the recommendations formulated by the participants at the Working Meeting on Indigenous Peoples and Health, held in Winnipeg, Manitoba, Canada, from 13 to 17 April 1993;

> Recognizing that the living and health conditions of the estimated 43 million indigenous persons in the Region of the Americas are deficient, as reflected in excess mortality due to avoidable causes and in reduced life expectancy at birth, which demonstrates the persistence and even the aggravation of inequalities among indigenous populations in comparison with other homologous social groups;

> Considering the aspiration of indigenous peoples to take charge of their own institutions and ways of life, the need for them to assert their own identity, and the need to respect their rights with regard to health and the environment;

> Recognizing the unique contribution that indigenous peoples make to the preservation of ethnic and cultural diversity in the Americas, to biodiversity and a balanced ecology, and most especially, to the health and nutrition of society;

> Emphasizing the need to take a new look at, and respect the integrity of, the social, cultural, religious, and spiritual values and practices of indigenous peoples, including those related to health promotion and maintenance and the management of diseases and illnesses; and

> Reiterating the importance of the strategy for the transformation of national health systems and the proposal for the development of alternative models of care at the level of local health systems as a valuable tactical resource and a fundamental requisite for dealing with current problems relating to insufficient coverage, inadequate access, and the lack of acceptability of health services on the part of indigenous populations,

Resolves:

1. To adopt Document CD37/20, which describes the initiative "Health of the Indigenous Peoples of the Americas," and the report of the Winnipeg Working Meeting containing the conclusions and recommendations on which the initiative is based.
2. To urge the Member Governments:

a) To facilitate the establishment or strengthening of a high-level technical commission or other mechanism of consensus, as appropriate, with the participation of leaders and representatives of indigenous peoples, for the formulation of policies and strategies and the development of activities in the areas of health and the environment for the benefit of specific indigenous populations;

b) To strengthen the technical, administrative, and managerial capacity of national and local institutions that are responsible for the health of indigenous populations with a view to progressively overcoming the lack of information in this area and ensuring greater access to health services and quality care, thus contributing to a higher degree of equity;

c) To implement intersectoral actions, as appropriate in each case, in the areas of health and the environment both in the official sector and through nongovernmental organizations (NGOs), universities, and research centers that work in collaboration with indigenous organizations;

d) To promote the transformation of health systems and support the development of alternative models of care, including traditional medicine and research into quality and safety, for indigenous populations within the local health system strategy;
e) To promote the development of disease prevention and health promotion programs in order to address these problems and the most important areas relating to indigenous health in their countries.

3. To request the Director, within the limits of available resources:
a) To promote the participation of indigenous persons and their communities in all aspects of PAHO's work on the health of indigenous persons;
b) To identify technical cooperation resources within existing cooperation programs and provide support for the mobilization of additional resources at the international and national level for implementation and evaluation of the initiative "Health of the Indigenous Peoples of the Americas";
c) To coordinate the regional effort by promoting the establishment of information and mutual cooperation networks between organizations, centers, and institutions whose activities are concerned with the health of indigenous peoples, organizations, and communities, enlisting the Organization's existing mechanisms, initiatives, and programs at the regional level and in the countries and also seeking the cooperation of other agencies and organizations;
d) To expand the evaluation of living conditions and the health situation to include the indigenous peoples of the Region, with a view to gradually overcoming the current lack of information in this area at both the regional and the country level;
e) To promote collaborative research at the regional level and in selected countries on high-priority health issues and health care for indigenous peoples.

(Adopted at the fourth plenary session, 28 September 1993)

RESOLUTION CD40.R6

> The XI Directing Council,

Having examined the report on the health of
> indigenous peoples (Document CD40/14);
Recognizing the growing evidence of inequities in health status and access to basic health services for the estimated 43 million indigenous
> persons in the Region of the Americas; and
Considering the economic, geographic, and cultural barriers to the efficient and effective delivery of public health and personal health care services in isolated rural and marginal urban areas in most countries,

> Resolves:

To take note of the report on progress in the implementation of Resolution CD37.R5, to reaffirm the commitment to the goals of the Decade of the Worlds Indigenous Peoples, and to approve the activities proposed in Document
> CD40/14.
To urge the Member States, in the process of the implementation of health sector reform, to be persistent in efforts to detect, monitor and reverse inequities in health status and access to basic health services for vulnerable groups,
> including indigenous peoples.
To call to the attention of Member States that renewal of the goal of health for all requires that sustainable solutions are found to address the economic, geographic, and cultural barriers to
> adequate care for vulnerable groups.
To request the Director to continue his efforts to implement the Health of Indigenous Peoples Initiative.

(Adopted at the eighth plenary session, 25 September 1997)

RESOLUTION CD47.R18
"HEALTH OF THE INDIGENOUS PEOPLES IN THE AMERICAS"

The 47th Directing Council,

Recognizing the progress achieved by the Health of the Indigenous Peoples Initiative and cognizant of the findings of the evaluation of the International Decade of Indigenous People of the World;

Taking note of the existence of inequities in health and access to health care services that affect more than 45 million indigenous people living in the Region of the Americas; and

Considering that the attainment of the internationally agreed-upon health-related development goals, including those contained in the United Nations Millennium Declaration, cannot be reached unless the specific health needs of excluded populations, such as the indigenous peoples, are addressed,

Resolves:

1. To approve the proposed strategic lines of action for PAHO's technical cooperation on the health of the Indigenous Peoples in the Americas.

2. To urge Member States to:

a) ensure the incorporation of indigenous peoples' perspectives into the attainment of the Millennium Development Goals and national health policies;
b) improve information and knowledge management on indigenous health issues to strengthen evidence-based decision-making and monitoring capacities in the Region;
c) integrate the intercultural approach into the national health systems of the Region as part of the primary health care strategy;
d) develop, together with PAHO/WHO, strategic alliances with indigenous peoples and other stakeholders to further advance the health of the indigenous peoples;
e) promote the training, education and leadership development of indigenous healers, and their incorporation in the health system formally, where appropriate;
f) promote the incorporation of the intercultural approach in the curricula of all training and degree programs in areas of health and related fields and its implementation in all health institutions;
g) promote the establishment of permanent mechanisms of consultation with indigenous communities for health decisions related to them;
h) train human resources from the health system to act as intercultural facilitators.

3. To request the Director to:

a) support the development and implementation of the proposed strategic lines of action for PAHO's technical cooperation, including the opportunity for developing a Regional Plan for the Health of the Indigenous Peoples;
b) advocate the mobilization of national and international resources to support efforts to improve the health of the indigenous peoples in the Region;
c) ensure the inclusion of the proposed strategic lines of action into the Pan American Sanitary Bureau Strategic Plan 2008-1012 and promote their inclusion in the Ten-Year Health Agenda for the Americas.

(Ninth Meeting, 29 September 2006)

Evaluation Instrument

EVALUATION OF THE INTERNATIONAL DECADE OF THE INDIGENOUS PEOPLES OF THE WORLD

Health of the Indigenous Peoples of the Americas: Achievements and Future Directions

EVALUATION INSTRUMENT

INTRODUCTION

The International Decade of the World's Indigenous Peoples (1995-2004) was proclaimed by the United Nations General Assembly in its Resolution 48/163 of 21th December, 1993 with the principal objective of strengthening international cooperation to contribute solving the problems that affects the indigenous peoples in areas such as human rights, environment, development, education and health. The permanent struggle of the indigenous peoples and the proposals of the indigenous movement were decisive factors in this proclamation.

The Pan American Health Organization (PAHO) and the Member Countries in order to contribute to the improvement of the health of the indigenous peoples of the Americas and in compliance with Resolutions CD37.R5 (1993) and CD40.R6 (1997) (Annex 1: Resolutions) and of the commitments of the Decade, has been promoting actions in favor of these peoples in the framework and the principles of the Health of the Indigenous Peoples Initiative.

Despite the progress experienced in the `Region of the Americas` there exists evidence of the inequity that affects the indigenous peoples of the Region. An adequate analysis of the progress and challenges that still persist in the countries in the health care of the indigenous peoples, development will support, or reorientation of the efforts under the way. In order to facilitate this evaluation, based on the experiences in the implementation of the Health of the Indigenous Peoples Initiative in the regional and national levels, the instrument that is presented in this document has been prepared.

The context for this evaluation is the conclusion of the International Decade of the Indigenous Peoples of the World (1995–2004), the renewed efforts to consolidate the Primary Health Care Strategy in the Americas to be fulfilled by the 25º anniversary of the Declaration of Alma Ata, and especially, the priority that PAHO is giving to the improvement of the health of the indigenous peoples of the Americas in the processes aimed at the achievement of the Millennium Development Goals.

Contact person

The progress reports and the results of the evaluation should be sent electronically (Office-Word) to Dr. Rocío Rojas, THS/OS to the following electronic address: rorojas@paho.org.

OBJECTIVE

Regarding the conclusion of the International Decade of the Indigenous Peoples of the World (1995-2004), to obtain information that facilitates the analysis of the progress, challenges, and approaches in the health to the indigenous peoples in the countries of the Americas in the context of the renewal of Primary Health Care Strategy and of the achievement of the Millennium Development Goals .[51]

[51] In the 1978, was held the International Conference about the Health Primary Attention (HPA) in alma-Ata, the health primary attention was identified as a principal strategy to reach the goal of Health for Everybody in the year 2000. In the region of the Americas, the countries assumed the four basic principles of the HPA: i) universal accessibility and coverage in function of the health needs; ii) commitment, participation, and individual and collective self-sustainment; iii) inter-sectorial action for health, and iv) cost-efficiency and proper technology according to the available resources. In the year 2003, having the Alma Ata Conference 25 years, the countries have renewed their commitment for the application of these principles. Article 25: 25 years after the Alma Ata (includes the Declaration about HPA).
http://www.paho.org/Spanish/DD/PIN/Numero17_articulo1_1.htm. In the year 2000, in the United Nations Millennium Summit, the world leaders of 91 countries agreed in several measurable goals and objectives with the respective deadlines in order to fight against poverty, hunger, illnesses, illiteracy, environmental degradation, and women discrimination. These goals, constitute the core of the world agenda, they are known with the name of Millennium Development Goals and constitute a framework so that all the countries and agencies of the United Nations' system work together in a coherent way for a common goal. The objectives and goals are explained in the following address: http://www.un.org/spanish/milleniumgoals/.

Principles

1) comprehensive approach of the health;
2) right of the indigenous peoples to the self-determination;
3) right to systematic participation;
4) respect for the indigenous cultures and their revitalization; and
5) reciprocity in relations.

METHODOLOGY OF EVALUATION

In the evaluation of the processes there will be taken into account the application of the five principles of the Initiative Health of the Indigenous Peoples ratified in resolutions CD37.R5 and CD40.R6

PREPARATION OF THE INSTRUMENT

The methodology followed in the preparation of the evaluation instrument included:

- Review of the advances in the implementation of Resolutions CD37.R5 and CD40.R6, within the framework of the Health of the Indigenous Peoples Initiative.
- Plan of Action 1995-1998 of PAHO/WHO for the Impetus of the Initiative in the Region of the Americas
- Progress Report
- Strategic Frame of Reference and Plan of Action 1999-2002 of the Health of the Indigenous Peoples Initiative.
- Strategic Guidelines and Plan of Action 2003-2004 of the Health of the Indigenous Peoples Initiative.

- International Decade of the Indigenous Peoples: 1995-2004: Achievements and Challenges in the Americas, April 2004 - Report to the Department of Ethics, Trade, Human Rights and Health Law (ETH) Sustainable Development and Healthy Environments (SDE) World Health Organization.
- Review of trip reports, correspondence maintained with the countries and other related institutions and technical documents sent by the countries
- Consultation with different professionals of PAHO, Ministries of Health, and Indigenous Organizations and experts.

PRESENTATION OF RESULTS

The methodology for the presentation of the results will include two phases:

a) collection and systematization of information and
b) presentation of the results in Consultation Meeting from 6 to 10 December. The people responsible for completing the instrument will be 3:

1. Director of the Technical Unit Responsible for Health of the Indigenous Peoples in the Ministry of Health. In absence of a Technical Unit, the professional responsible for the health care of the indigenous peoples in the Ministry of Health.
2. Indigenous representative
3. Focal Point of the Health of the Indigenous Peoples Initiative of PAHO

Those responsible for completing the instrument will attend the consultation to be carried out from 6th to 10th December, 2004 and will make a combined presentation of 20 minutes of duration on the results obtained.

TIMETABLE

Date, 2004	Activity	Responsible
15 July	Shipment of the instrument to the countries	Dr. Rocío Rojas, THS/OS
15 August	First progress report–Includes names of the people who will be responsible for completing the instrument and as a result will represent the country in the Consultation to be carried out from 6 to 10 December, 2004.	Focal Points of the Initiative Health of the Indigenous Peoples
15 September	Preliminary version of the evaluation	Focal Points of the Initiative Health of the Indigenous Peoples
30 September	Sending of the first regional report consolidated for inspection of the countries	Dr. Rocío Rojas, THS/OS.
15 October	Shipment of contributions to the consolidated regional report	Focal Points of the Initiative Health of the Indigenous Peoples
15 November	Sending of the presentations from the countries to the Consultation meeting.	Focal Points of the Initiative Health of the Indigenous Peoples
30 November	Final Regional Report. The end CD with the presentations of the countries	Dr. Rocío Rojas, THS/OS.
6-10 December	Consultation	Planning Committee

STRUCTURE OF THE EVALUATION INSTRUMENT

FIRST PART

The first part of the instrument consists of 4 sections based on the explicit commitments in the articles of Resolutions CD37.R5 and CD40.R6, of the principles and areas considered in the processes of implementation of the Health of the Indigenous Peoples Initiative:

1. International agreements and national policies
2. Strategic partnerships and networks of interinstitutional and intersectoral collaboration
3. Primary health care and cultural diversity
4. Information, analysis, monitoring, and management

Each one of the sections is divided into tracer issues that will facilitate the evaluation. In this section illustrative examples of several countries are included.

SECOND PART

The second part contains a list of questions and a strategic analysis matrix that will support the identification of the directions for future work.

THIRD PART

The third part of the instrument contains available information on demographics and evidence on the inequity that affects the indigenous peoples of the Region. In this section it is requested that the countries update the information on table 1 incorporating the respective bibliographic source and the preparation of a table similar to the table 2 with national data.

FIRST PART

Complete the matrixes of each section:

1. International agreements and national policies

EPIS:

International Agreements	Legal Framework		Technical Units responsible for the health of Indigenous Peoples	
	Constitution/ National Policies	Health Policies	Government Bodies/ Ministry	Contact Information

Example:EPIS: Mexico

International Agreements	Legal Framework		Technical Units responsible for the health of indigenous Peoples	
	Constitution/ National Policies	Health Policies	Government Bodies/ Ministry	Contact Information
Convention 169 ILO[3] Resolution CD37.R5 Resolution CD40.R6[4]	Article 4: The Mexican nation has a multicultural composition sustained originally in its indigenous towns Law 21/05/2003–Law of the National Commission for the Development of the Indigenous Peoples	**2004.** Insurance Popular for Indigenous Peoples, focused to meet the health needs of the indigenous population.	>National Commission for the Development of the Indigenous Peoples dependent on the Presidency of the Republic Assistant Director's Office of >Strategic Programs in Indigenous Rural Areas, General Bureau of Management of Health Services. National Commission of Social Protection in Health. Ministry of Health	Mr. Carlos Zolla czolla@att.net.x Dr. Gonzalo Solis Cervantes leogonsol@hotmail.com The Pines Mexico, Federal District Tel 5651 3199 Mr. Luciano Rangel Castillejos Assistant Director lcastillejos@salud.gob.mx

[3] The 169 ILO Convention (1989) has been ratified by the following countries: Argentina, Bolivia, Brasil, Colombia, Costa Rica, Dominica, Ecuador, Guatemala, Honduras, Mexico, Paraguay, Peru, Venezuela (OIT, 2004: http://www.ilo.org/ilolex/english/convdisp1.htm)

[4] The 35 PAHO Member Governments expressed their commitment to prioritize care of the indigenous peoples of the Americas upon adoption of Resolution CD37.R5 (1993) y CD40.R6 (1997). The Member Governments are: Antigua and Barbuda, Argentina, Bahamas, Barbados, Belize, Bolivia, Brazil, Canada, Chile, Colombia, Costa Rica, Cuba, Dominica, Dominican Republic, Ecuador, El Salvador, Grenada, Guatemala, Guyana, Haiti, Honduras, Jamaica, Mexico, Nicaragua, Panama, Paraguay, Peru, Saint Lucia, St. Vincent and the Grenadines, St. Kitts and Nevis, Suriname, Trinidad and Tobago, Unites of America, Uruguay and Venezuela.

2. Strategic Partnerships and networks of interinstitutional and intersectoral collaboration

Agreements	
National projects, interinstitutional/interesectorial	
Projects multicountry	
Interinstitutional/intersectoral forums	
Indigenous organizations that include the approach of the health in its political agendas.	
Networks	

Example: COUNTRY: Colombia

Agreements	PAHO-Ministry convention 221 of the Social Protection for the definition of policies and social protection strategies in health to the ethnic groups
Interinstitutional/interesectoriales projects	Project: "Basic Water Supply and Sanitation for Indigenous Populations in Colombia." Participating institutions: Ministry of Environment, Housing, and Territorial Development, Ministry of the Interior and of Justice, Ministry of the Social Protection, Pan American Health Organization, Organization of Indigenous Peoples of the Amazon region of Colombia--OPIAC
Multi-countries Projects.	Colombia-Ecuador TCC--: "Systematization and sharing of experiences in the organization and management of health Services decentralized for indigenous populations."
Interinstitutional/intersectoral forums	National Working Group of the project "Basic Water Supply and Sanitation for Indigenous Populations in Colombia"
Indigenous organizations that include the approach of health in their political agendas	Organization of Indigenous Peoples of the Amazon region of Colombia - OPIAC
Networks	The Amazon Network of Health Indigenous Population--SIAMA - based in 2001 by several NGOs and indigenous organizations of the Amazon region as a strategy to join efforts and work together. The Network has had the support of the Dutch Organization for Cooperation to Development International, Novib--Oxfam Netherlands entity other institutions. The network is coordinated by FOUNDATION ETNOLLANO Airmail box 103,263, Fax: 57-1-2149094. Bogotá--Colombia, And--mail:enred@etnollano.org

3. Primary health care and cultural diversity

Country:	
Policies that promote the incorporation of the perspectives, medicines, and indigenous therapies in the National Health Programs.	
Experiences of harmonization of the indigenous health systems and conventional.	
Indigenous therapist associations	
Training and `human resources development` programs (research and fellowships)	

Examples:

Country:	
Policies that promote the incorporation of the prospects, medicines, and indigenous therapies in the National Health Programs.	In Health Policies and Strategies 2000-2004 of the Ministry of Health of Panama, the new orientation of the policy of health directed to the indigenous populations has as strategy "to adapt the health programs in the indigenous regions in relation to the cultural patterns of the various ethnic groups." This orientation includes the "rescue of traditional medicine and linkage with the midwives and traditional physicians" (OPS-Estudio de Caso Panamá, 2000).
Experiences of harmonization of the indigenous health systems and conventional.	In Nicaragua, as a result of the implementation of the autonomic model in the administration of the government, the Autonomous Regional Council of the Autonomous Region of the Atlantic North, by means of the Health Commission, took on the challenge of designing a health model that could correspond to the needs for the peoples Miskito, Sumu-Mayangna, Criollo*, and Hybrid (University of the Autonomous Regions of // the Nicaraguan Caribbean Coast, 1996).
Indigenous therapist associations	Association of Yachacs of Otavalo, Ecuador
Training and `human resources development` programs (research, fellowships)	Master's degree in Public Health, experience in research since 1984. Multidisciplinary team of research. Areas of emphasis: indigenous `maternal and child` health, health and `human resources education` education: health professionals and promotive. Gender approach and ethnic group.

4. Information, analysis, monitoring, and management

Information on the demographic, socioeconomic and epidemiological profile of the indigenous peoples	
Information systems, monitoring, and evaluation of the health of the indigenous peoples includes the variable of ethnic group.	
Maps of the location of the indigenous peoples in the countries in accordance with the political division of the country (includes the map in the Annex)	
Characterization of the indigenous peoples with regard to their health and living conditions, social organization and systems of beliefs and values that influence the maintenance and restoration of its health.	
Periodic publications on the health of the indigenous peoples	
Section on health of the indigenous peoples on the Web page of the Ministries of Health, PAHO, or other institutions (electronic address)	

Examples:

Information on the demographic, socioeconomic and epidemiological profile of the indigenous peoples	USA: - Indian Health Service: Regional Differences in Indian Health 1998–99 http://www.ihs.gov/PublicInfo/Publications/trends98/region98.asp
Information systems, monitoring, and evaluation of the health of the indigenous peoples includes the variable of ethnic group.	Canadá: - First Nations and Inuit Health – Health Canada - First Nations and Inuit Control, Annual Report, 2001-2002 http://www.hc-sc.gc.ca/fnihb-dgspni/fnihb/bpm/hfa/fnic_annual_report_2001_2002.htm
Maps of location of the indigenous peoples in the countries in accordance with the political division of the country (includes the map in the Annex)	Ecuador (MAP - Annex)
Characterization of the indigenous peoples regarding their health and living conditions, social organization and systems of beliefs and values that influence the maintenance and restoration of its health	Health care of the Indigenous Peoples of Honduras: Cultural Diversity and Processes of National Convergence
Periodicals on the health of the indigenous peoples	Canadá – First Nations and Inuit Health – Health Canada Progress Report
Section on health of the indigenous peoples on the Web page of the Ministries of Health, PAHO, or other institutions (electronic address)	PAHO/WHO Representative Office-Nicaragua http:/www.ops.org.ni// http://www.ops.org.ni/opsnic/topics/indigenous population//

SECOND PART

1. **Which are the most relevant achievements in the health care of the indigenous peoples in the period 1995-2004?**

2. **Which are the priority problems in the health care of the indigenous peoples of the country in the national and subnational area?**

3. **Which are the aspects to consider in the insertion of the health of the indigenous peoples as a priority in the processes that the country is promoting in the renewal of the Strategy of Primary Care and in the achievement of the Millennium Goals?**

Complete the following matrix:

Strategic Analysis	
Strengths: characteristics specific of the country that would facilitate the actions aimed at the improvement of the health of the indigenous peoples.	**Weaknesses:** negative aspects within the country that would hinder the actions aimed at the improvement of the health of the indigenous peoples.
Opportunities: factors that are in the context, and that it is thought that will act in favor of the actions aimed at the improvement of the health of the indigenous peoples.	**Threats:** negative factors that can affect the implementation of actions aimed at the improvement of the health of the indigenous peoples.

THIRD PART

Update the information on the table 1 and to prepare table similar to table 2 with national data.

Population and indigenous peoples of the Americas

(population expressed in thousands of inhabitants)

Population		Population National	Indigenous Population	%	Peoples
Proporción	1. Bolivia	7.960	5.652	71	32
More than 40%	2. Guatemala	10.801	7.129	66	23
	3. Peru	24.797	11.655	47	51
	4. Ecuador	12.175	5.235	43	12
	Sub total	55.733	29.671	53	118
	5. Belice	230	44	19	2
	6. Honduras	6.147	922	15	7
	7. Mexico	95.831	13.416	14	59
From 5 to 20%	8. Chile	14.824	1.186	8	5
	9. El Salvador	6.032	422	7	3
	10. Guyana	850	51	6	9
	11. Panama	2.200	132	6	7
	12. Suriname	414	25	6	6
From 1 to 4%	13. Nicaragua	4.807	240	6	6
	Sub total	131.335	6.438	13	104
	14. French Guayana	100	4	4	6
	15. Canada	29.100	1.045	3	3
	16. Paraguay	5.222	157	3	18
	17. Colombia	40.803	816	2	81
	18. Venezuela	23.242	465	2	28
	19. Caribbean islands	8.406	162	2	1
	20. Argentina	36.123	361	1	15
	21. Costa Rica	3.841	38	1	8
	Sub total	146.837	3.048	2	160
Less than 1%	22. Brazil	165.851	332	0	197
	23. United States	260.800	1.959	0	166
	24. Uruguay	3.289	1	0	
	Sub total	429.940	2.292	0	363
	Grand Total	763.845	51.449	6.7	745

Sources: IPES, 1999; Jordán Pando, 1990: III-FAO; and `Inter-American Indian Institute`, Indigenous America, vol. LIII, No.4, October - December, 1993, IDB, 2002.

Table 2. Challenges, factors to consider, and inequities

Challenges

Strategies of health and public health should include and address the structural factors, of risk and to be inserted in the strengths of the indigenous peoples:

- Holistic vision of the well-being of the individual, of the family, the community, and environment
- Cultural capacities, linguistic, organizational, of negotiation and leadership
- At the beginning community adherence of reciprocity, solidarity and respect and ancestral knowledge

Factors to consider

- **Location :** The indigenous population, in general is scattered, in some cases mobile remote and for the most part localized in rural areas, urban fringe, and border. Several indigenous peoples are multinational as the Miskito of Nicaragua and Honduras, the Quechuas of Colombia, Ecuador, Peru, Bolivia, Argentina, etc. (OPS, 2002).

- **Ethnic heterogeneity and cultural:** Brazil: the Brazilian indigenous population is estimated in 350,000 people, belonging to nearly 210 peoples that speak more than 170 languages. Although it constitutes 0.2% of the total population, the indigenous population is present in 24 of the 26 states of the country (OPS, 2003).

- **Culturally appropriate care :** In the evaluation of the Essential Public Health Functions, Function 8: `human resources development` and training in public health, including the capacity to provide culturally appropriate health care, presents a performance under (38%) in the Region, and 17% for culturally appropriate care (OPS, 2002)

Inequities

- **Poverty :** Ecuador: in the rural areas of the mountains and of the Amazon region, areas with indigenous population, is estimated that 76% of the children, are poor (OPS, 1998)

- **Illiteracy :** Peru: in the Peruvian Amazon region, 7.3% do not have any level of instruction, compared with 32% in the indigenous communities (INEI-UNICEF, 1997).

- **Unemployment :** El Salvador: unemployment among the indigenous population is 24% (OPS, 2002).

- **Basic services:** El Salvador: 33% of the indigenous population have electricity and 64% use oil-lamp or candle. 91.6% consume river water, or well (OPS, 2002).

- **Infant mortality:** Mexico: the infant mortality rate among the indigenous children was of 59 per 1,000 live births in 1997, twice as high as the national (OPS, 2002).

- **Maternal mortality:** Honduras: maternal mortality rate, national average 147 x 100mil live births In the departments of Columbus, Copán, Intibucá, Lempira and La Paz, areas with indigenous population, the maternal mortality rate ranges between 255 and 190 x 100,000 live births (OPS, 1999)

- **Malnutrition:** Guatemala: chronic malnutrition is 67.8% among the indigenous population and of 36.7 among the non-indigenous (OPS, 2002).

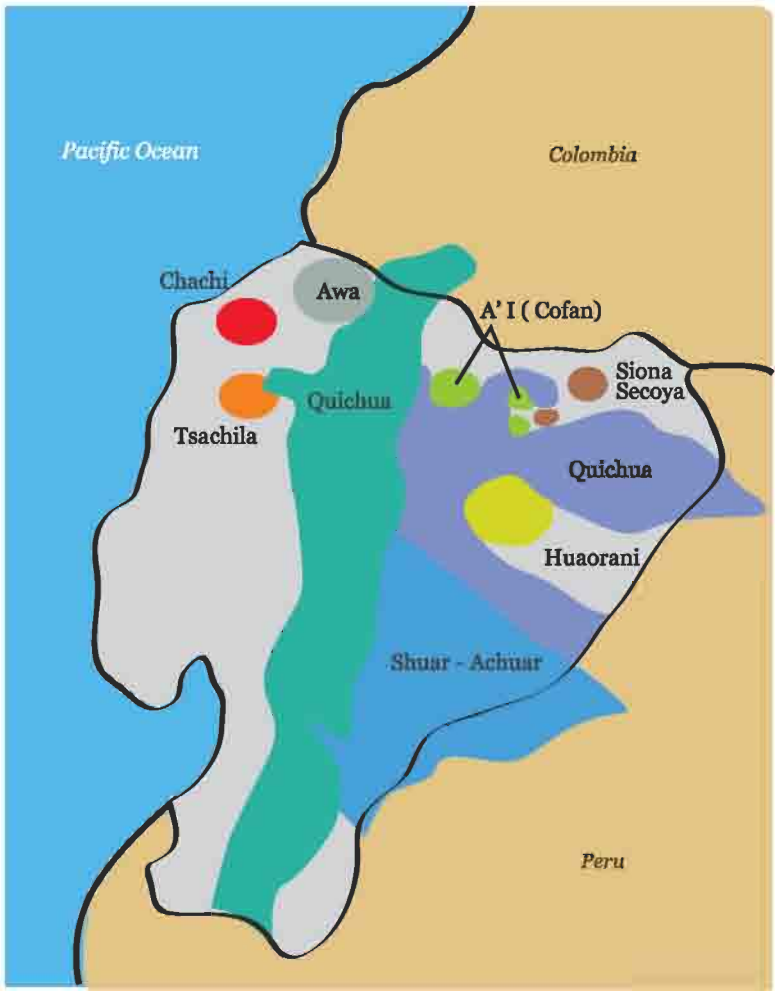
- **Infectious Diseases:** Nicaragua: the municipios affected by plasmodium falciparum are localized in the Autonomous Regions of the Atlantic Coast of the country, area of settlement of indigenous and afrodescendientes peoples (OPS-NIC, 2003).

- **Diabetes, obesity, alcoholism:** the United States: the indigenous population has many more probabilities of dying of diabetes mellitus related to obesity and of disease of the liver by the alcohol abuse, compared to the general population (OPS, 2003).

- **Suicide:** Canada: the rate of suicide is from two to seven times higher between the indigenous population that in the population in general and is cause of concern especially among the young men of the communities inuit (OPS, 2002).

Observations

Indigenous peoples in **Ecuador**



Estimated population of Indigenous people in Ecuador	
Pacific Coast	
Awa	1.600
Chachi	4.000
Tsachila	2.000
Highlands	
Quichua	3.000.000
Amazonas	
Quichua	60.000
Cofan	800
Siona - Secoya	1.000
Shuar	40.000
Achuar	500
Huaorani	2.000

Source: CONAIE, 2000

Regional Evaluation Meeting: Roundtable Summary

The roundtable summary presented below reflects the results of discussions held in the plenary and work groups within the framework of the Regional Meeting "Health of the Indigenous Peoples of the Americas: Achievements and Future Guidelines" held in Managua, Nicaragua from December 6 to 8, 2004. The recommendations of the participants in the Regional Meeting have been incorporated into the document "Regional Health Program of the Indigenous Peoples of the Americas: Core of Work and 2005–2015 Action Plan". The roundtable summary has been organized in three parts:

1. General Comments
2. Comments on the document "Regional Health Program of the Indigenous Peoples of the Americas: Core of Work and 2005–2015 Action Plan" – November 2004 version.
3. Results of the matrix of analysis in the following subject areas:

> Advocacy, development of technical capacity and coordination.
> Policies and focus on the Millennium Development Goals.
> Information and knowledge management.
> Primary Attention to Health and Cross-culturality.

GENERALS COMMENTS

> It is necessary to ratify and apply the resolutions and international, regional, sub-regional agreements that have to do with the health of indigenous peoples.
> A conceptual review that includes the indigenous peoples approach is imperative.
> An evaluation of the International Decade of the World's Indigenous Peoples is lacking from other United Nations System agencies in order to have an integral approach of the health situation of indigenous peoples.
> It is essential that the proposal to transform the Initiative into a Health of Indigenous Peoples of the Americas Program that is effectively implemented has a follow-up and evaluation system and adequate resources are allocated.

COMMENTS TO THE DOCUMENT

> Indigenous representatives of Group #4 considered that the strategies defined in all parts of the Program's document do not satisfy their needs but are aimed at institutional goals.

> It is important to specify verifiable indicators.

> It is necessary to check the wording of some objectives, expected results and activities.

> It is necessary to include reference information and additional activities.

> It is important to carry out periodical evaluations to know about the progress in the Program's application.

RESULTS OF THE ANALYSIS MATRIX

ADVOCACY, DEVELOPMENT OF TECHNICAL CAPACITY AND COORDINATION (part 1)

Lessons learnt	What we need	How we can do it	How we can measure it
Health care for indigenous peoples is a dynamic process that not only demands commitment, but its implementation through financing, direct participation of indigenous peoples, monitoring, evaluation and regulations.	Alliance with local governments with support, follow-up and evaluation.	Diagnosis of the health situation with indigenous participation.	Lines of action implemented resulting from the diagnosis
Participatory processes for agreement and dialogue should be carried within the countries for the design of public policies	Process appropriation by the indigenous peoples. Within the Caribbean context, there should be more NGOs to provide services and promote participation.	Training indigenous health promoters from an cross-cultural perspective and also training health officers' tools, methodologies and regulations.	Methodological processes developed for policy design.
	To strengthen indigenous representativeness processes in decision making	Guaranteeing space for participation.	Indigenous participation in local spaces in a balanced and representative way.
	To build processes in a joint manner starting from the needs, problems and proposals made by the indigenous peoples themselves.	Strengthening indigenous identity.	Number of renowned indigenous organizations and involved in decision making.
	Start from a knowledge dialogue within the context of respect and mutual enrichment, responsibility, commitment and participation.	Carrying out public campaigns for cultural diversity	Number of campaigns carried out.

RESULTS OF THE ANALYSIS MATRIX

ADVOCACY, DEVELOPMENT OF TECHNICAL CAPACITY AND COORDINATION (part 2)

Lessons learnt	What we need	How we can do it	How we can measure it
Participatory processes for agreement and dialogue should be carried out within the countries for the design of public policies		Acknowledging and valuing cultural identity by the non-indigenous people.	Number of laws, sectorial policies, programs and documents that acknowledge diversity (education, health, environment, employment, social security, territory...)
	Indigenous people participation from the definition to implementation, follow-up and evaluation of policies	Creating legal tools to make ILO Agreement 169 operational.	Number of tools that appear since 2005 and take into account initiatives from the communities.
	To strengthen indigenous organizations.	Monitoring economic resources assigned to health matters.	Care model based on the needs and cultural characteristics of indigenous peoples.
	Institutionalization of spaces to approach health from an integral, intra-institutional, inter-institutional and inter-sectorial perspective.	Creating spaces for indigenous representation from local to national level.	Through accountability
	To promote the rights of indigenous peoples within the framework of autonomy and empowerment of the peoples.	Defining a base line.	Number of representativeness occasions. Number of networks working. Planning spaces
	To strengthen indigenous organization instances (traditional associations, indigenous organizations)	Cultural mediation with technical support and training.	Number of training events and exchanges carried out.
	Processes supported by international bodies should start from cosmovisions of the indigenous peoples, should have a satisfactory impact with shared social control and follow-up.	Exchange of information between countries and network generation.	

	To start from the holistic health vision as the indigenous cosmovision proposes.	Opening spaces for: a) planning b) cultural competence, c) individual empowerment.	
A State policy focused on the right to health of indigenous peoples should be defined	Take into account the participation of the indigenous representation starting from planning, design, follow-up and evaluation in order to define health policies.	Raising awareness of national, regional and local authorities about the importance of this matter. Empowerment of indigenous peoples about their rights to integral development, especially the right to health and education. Creating structures in health institutions that make operational the policy with legal support for its functioning. Identification of participation mechanisms, community, institutional, inter-institutional workshops, indigenous people discussion seminars at each moment of the process. Advocacy at all levels.	Mechanisms that make indigenous participation official Number of decision-making instances with indigenous participation. Incorporation of the indigenous subject in the country's work.
A State policy focused on the right to health of indigenous peoples should be defined	To be clear in the definition of the principles of social inclusion, equity, cross-culturality, in order to make the policy operational, and they should be discussed and agreed with indigenous and other sector's participation	Generating discussion groups at different levels to achieve consensus in the definition of principles for a sustainable national policy	Existence of democratic and/or consensus mechanisms to guarantee representativeness of indigenous peoples at local, regional and national level.
	To cross-cut the health component, indigenous peoples in health programs to offer a service package	Defining the approach for care of the indigenous peoples within the programs that function in each Ministry, through consultations to users and traditional specialists.	Number of technical units in the Ministries of Health that include the cross-cultural health approach.
	To guarantee sustainability of the processes to be implemented. To raise awareness in governments about the importance of health indigenous peoples' programs for resource allocation.	Engaging the government for a regular and adequate allocation for the needs of integral care of the health of indigenous people.	Number of agreements between indigenous organizations and governments for the development of joint plans, program implementation, training, research, internships, scholarships that allow young indigenous people to have better living perspectives.

RESULTS OF THE ANALYSIS MATRIX
ADVOCACY, DEVELOPMENT OF TECHNICAL CAPACITY AND COORDINATION (part 3)

Lessons learnt	What we need	How we can do it	How we can measure it
A State policy focused on the right to health of indigenous peoples should be defined	To strengthen indigenous leadership focused on the search for general welfare of indigenous groups with a consensus approach of all peoples of a country.	Creating structures in health institutions that make the policy operation with legal support for its functioning, guaranteeing equal support of indigenous representatives in addressing the process. Generating alliances of the indigenous people organizations, instance of the civil society, cooperation agencies and the State for the management and investment of resources in response to the actions defined in the national policy of indigenous peoples.	Number of cooperation, exchange and resource mobilization agreements within the country and between countries.
Debe definirse una política de Estado enfocada al derecho a la salud de pueblos indígenas.	A permanent PAHO Secretariat to promote indigenous health subjects; it could become a special advisor at the Organization's Direction level.	Encouraging PAHO to play an advocacy role in the health of indigenous peoples' subject at international fora, including the promotion of regional strategies.	Attendance of PAHO and indigenous representatives, as well as the Ministries of Health in international and regional forums.
	Alliances between indigenous peoples within and between the countries.	Promoting exchanges between indigenous peoples.	Number of joint projects. Number of cooperation agreements.
	Training in advocacy	Providing technical support in the development of instruments and training methodology.	Training modules.
	Review PAHO documents, including an indigenous vision.	Analysis of the answers that the indigenous peoples have developed to face their health situation, with an emphasis on promoting self-determination.	Conceptual frameworks and operational strategies agreed with indigenous peoples.

RESULTS OF THE ANALYSIS MATRIX

POLICIES AND FOCUS ON THE MILLENIUM DEVELOPMENT GOALS

Lessons learnt	What we need	How we can do it	How we can measure it
Millennium Development Goals (MDG) do not include the indigenous vision in its conceptual framework, or indigenous representativeness in its implementation processes.	To complete the Millennium Development Goals with a specific focus of indigenous peoples. To evaluate compliance of the Millennium Development Goals (MDG) starting from disaggregating information by ethnic belonging.	Promoting participation of indigenous representatives in MDG processes. Developing information systems and information that considers the ethnics variable with full indigenous participation.	Incorporation of the indigenous vision into the MDG. MDG compliance evaluation starting from disaggregating information by ethnic belonging.

RESULTS OF THE ANALYSIS MATRIX
INFORMATION AND KNOWLEDGE MANAGEMENT (part 1)

Lessons learnt	What we need	How we can do it	How we can measure it
There is legislation on patents of products coming from ancestral knowledge.	To spread legislation related to patents, as well as those activities that can be performed within indigenous territories and the necessary environmental impact studies.	Opening spaces for discussion and analysis of the current legislation	Incorporation of the discussion on existing legislation in the institutional and indigenous agendas.
There is information focused on rescuing cultural values, but not on aspects that go against such cultural values of the indigenous peoples.	To spread the experiences carried out in the Americas region and with other ethnic groups of the world.	Promoting exchange encounters, visits, internships, web site.	Number of encounters carried out. Number of experiences replicated inside the country and in other countries. Number of initiatives developed.
	To report aggressions against indigenous peoples of the Americas regarding illegal territory exploitation, violations to human rights concerning health and life.	Presenting formal complaints Creating public opinion through informal complaints before the media.	Number of complaints presented.
	To include the risk factors that indigenous peoples face (environmental, social, health and economic-related, etc) and protective factors that influence the well-being of indigenous peoples in information systems.	Setting up a geo-referenced risk information system that allows decision-making. Building indicators to evaluate the holistic health and care quality concept. Starting from the risk perception that indigenous peoples have.	Social validation of the risk map. Setting-up of risk mitigation measures.
	To know what is produced concerning medicines and how they are produced.	Defining laws that oblige companies and the State to disclose this information.	Countries with legislation concerning medicine control and transgenic food.

There is information focused on rescuing cultural values, but not on aspects that go against such cultural values of the indigenous peoples.	To improve communication towards communities that are farthest from urban centers and that will be the most heavily affected by environmental projects.	Informing about the projects to the various affected groups or beneficiaries through the media, of documents translated to indigenous languages.	Number of projects and programs with community intervention.
	To release the methodology developed in countries within training health programs to incorporate elements of traditional medicine and the cross-cultural approach.	Encouraging PAHO to release to universities and science health schools about the progress in the incorporation of the cross-cultural approach.	Number of answers and topics incorporated into the study plans of schools and health sciences of each country.
	To reduce the gap of access to technological knowledge by indigenous peoples.	Developing an equal State policy regarding technological Access by indigenous peoples.	Spreading systems according to the characteristics of the indigenous peoples.
	To introduce the ethnics and cross-culturality variable in information systems to allow the strengthening of health supervision and services in order to compare between groups and guarantee resource management and reorientation of the program's strategies.	Definition and validation of indicators to guarantee the implementation of the ethnicity variable.	Indicators concerning ethnic belonging incorporated into information systems.
	To regulate research developed in indigenous locations to guarantee full respect of intellectual property and to disclose their results in the population that provided the knowledge.	Creating the national regulatory framework for evaluation and approval of projects addressed to indigenous peoples. Creating mechanisms for the socialization of project proposals in indigenous communities. Creating surveillance processes with the participation of various organizational structures of indigenous peoples. Creating mechanisms for the disclosure of results of the research developed. Guaranteeing that the communities, when being benefited by a project, participate in all its phases.	Existence of a regulatory framework Mechanisms developed. Surveillance Rules established. Mechanisms developed. Guidelines established.

RESULTS OF THE ANALYSIS MATRIX
INFORMATION AND KNOWLEDGE MANAGEMENT (part 2)

Lessons learnt	What we need	How we can do it	How we can measure it
There is information focused on rescuing cultural values, but not on aspects that go against such cultural values of the indigenous peoples.	To create approval, control, and project monitoring mechanisms for projects developed in indigenous populations and their systematic measurement.	Carrying out periodic evaluations on the progress of the projects implemented.	Evaluations results.
	To prepare culturally adequate documents with information addressed to the population.	Creating information bulletins Designing websites with topics related to indigenous peoples. Involving the population in the design and preparation of documents and programs. Taking into account language elements to expand the information's spreading	Bulletins published with indigenous participation and in indigenous languages. Websites with indigenous participation.
		Creating permanent education programs in subjects related to the health of indigenous peoples regarding environment, food safety, consumption of products free from genetic contamination. Promotion and appreciation of the community's traditional products.	Number of educational programs. Number of native products incorporated into the population's diet and native species protection programs.

PRIMARY ATTENTION TO HEALTH AND CROSS-CULTURALITY

Lessons learnt	What we need	How we can do it	How we can measure it
There is no epidemiologic profile with a cultural approach of the indigenous peoples.	To perform evaluations which measure the impact of the Primary Health Care Strategy with indicators of indigenous peoples' health	Defining indicators from the indigenous cosmovision.	Number of epidemiologic profiles with cultural approach.
Community participation according to the western system, but not with a cultural approach.	To establish relationship networks and knowledge exchange between institutions and the indigenous peoples.	Promoting cross-cultural education and health encounters. Creating realistic participation spaces.	Number of networks and alliances established.
There are limitations in health service.	To develop strategies to reproduce new healthy habits in schools and communities, starting from their own culture and with personnel from the communities themselves.	Socializing and validating the strategy of healthy indigenous schools.	Number of healthy spaces in place and culturally accepted.
No information has been synthesized on the progress of Primary Health Care in zones with indigenous population	To promote culturally competent care linked to the health network (first, second and third care level).	Certifying culturally competent health units. Building criteria and indicators for the certification of establishments.	Licensing and cross-cultural certification system available. Number of establishments or health units that are culturally adequate.
Trend to privatization and weakening of health public services and Primary Health Care	Revitalize the Primary Health Care Strategy within the Sectorial Reform.	Promoting actions in cross-culturality and health within the framework of the APS strategy renewal.	Prioritization of health care for indigenous peoples within the APS framework.

Regional Meeting: Managua Declaration issued by indigenous leaders

HEALTH OF INDIGENOUS PEOPLES: CHALLENGES IN THE ACHIEVEMENT OF EQUITY
Special session of Indigenous leaders

Within the framework of the Decade of the World's Indigenous Peoples Declaration, we acknowledge some achievements in the strengthening of the health of Indigenous Peoples. As a result, the "Health of Indigenous Peoples of the Americas Initiative" was created, in this context we propose that this effort should be framed within a "Health of Indigenous Peoples of the Americas Program" to allow us address the design of public policies according to the indigenous and national reality, which will lead us towards cross-cultural health models.

Therefore, we propose the following challenges for the achievement of the Millennium Development Goals:

To strengthen culture and spirituality of the indigenous peoples, influencing, preparing and transforming legal framework of each country.

To make sure the different governments of the Region engage to the work of the design of public policies that will become in true actions to improve living conditions of the indigenous peoples.

To strengthen the indigenous peoples institutionally, with the necessary means and resources.

To seek coordination between the State's instances, international cooperation organisms with indigenous peoples.

To strengthen the indigenous peoples' political capacity to achieve the design and negotiation of a health agenda.

To create and strengthen our spaces to discuss the health topic from our perspective.

To create our own information and exchange networks without risking our knowledge.

To invest in processes, so that they are not conceived from our peoples and executed from central management.

To approve and comply with international agreements in favor of our indigenous peoples in the states of the Americas.

To make the health systems of the different indigenous nationalities be recognized.

To achieve real participation of the indigenous peoples in health programs and projects.

To disclose and exchange success experiences that the indigenous peoples of the Americas are developing.

The indigenous peoples follow closely and fight for the respect of our cosmovision in relation to international treaties and agreements and the megaprojects being designed and executed in our regions.

Direct coordination of the indigenous peoples, strengthening social control by the indigenous peoples.

The indigenous peoples are not the instrument for projects and programs developed by governments, but instead that they decide their own needs

prioritized from a true equitable and leading participation,

To implement an ethnic-development proposal and an indigenous policy plan, in the habitat that indigenous peoples and communities have in order to help resolve the deficiencies and reaffirm the identity and autonomy of indigenous peoples. Such policies will have a specific character linked to the socio-cultural reality and indigenous lifestyle.

To make politicians and public and private officers understand the holistic vision of the health of the indigenous peoples.

The poverty indicators used to characterize indigenous peoples are reviewed, so that indigenous peoples are perceived correctly, without disrespecting their dignity (the indigenous peoples are part of a rich millennial biodiversity).

To make cross-cultural dialogue become a complementary strategy of health systems.

To create capacities in indigenous peoples to take advantage of the positive elements of the occidental world for socio-economic development.

We demand that all projects and actions addressed to the indigenous peoples of the Americas are encompassed within the framework of the PAHO Health of Indigenous Peoples of the Americas Program and are guided by the principles that orient the program.

That the indigenous subject is put into context within the framework of the health sector reform and that primary health care is not endangered by privatization intentions.

Managua, Nicaragua, December 8, 2004

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