

HEALTH OF THE INDIGENOUS PEOPLES

**HEALTH CONDITIONS OF ABORIGINAL PEOPLES IN
BELIZE, GUYANA AND SURINAME**



**Pan American Health Organization
Pan American Sanitary Bureau • Regional Office of the
World Health Organization**

**Washington, D. C.
junio 1998**

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HEALTH CONDITIONS OF ABORIGINAL PEOPLES

IN

BELIZE, GUYANA, AND SURINAME

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HEALTH CONDITIONS OF ABORIGINAL PEOPLES IN BELIZE, GUYANA, AND SURINAME

EXECUTIVE SUMMARY

PAHO commissioned this study as part of its renewed emphasis on the health of aboriginal peoples ratified in its 1993 Council of Directors meeting. The objective is to describe the health conditions of aboriginal peoples in the Circum-Caribbean and to suggest project profiles for intervention. Limitations in funds narrowed the selection to three countries - Belize, Guyana, and Suriname.

In order of decreasing morbidity vector borne diseases, infectious disease, and nutritional deficiency are the three sets of maladies that are wreaking the most havoc among the aboriginal peoples in the three countries. These are demanding the most attention. Not to be overlooked, of course, are chronic diseases, prevalent within these countries and also afflicting several aboriginal peoples. They include diabetes, hypertension, and associated complications.

Malaria is the disease most commonly found among aboriginal peoples. The other two are acute respiratory infection and diarrhea. With respect to nutrition, shortages in the food supply are pressing especially for infants at the point of weaning, school age children, and child bearing women. While these are problematic especially in Suriname and Guyana, the Belize study pinpoints anemia together with micronutrient deficiencies in vitamin A and zinc among other minerals.

The immediate cause of the above problems is inadequacy in the system of health delivery. Health facilities in the communities are understaffed, undersupplied, and are in decried physical conditions. The inaccessibility of the communities result in very low percentages in meeting targets under the expanded immunization programme. Finally, there is minimal support extended to Community Health Workers, who are forced to work with little training, supervision, and long delays in receiving their stipends.

In the study these global findings are complemented with country specific data. Aboriginal peoples in Suriname are the ones in the worst conditions because of the total breakdown of health delivery in the Interior during the six year guerrilla war which ended in 1992. Furthermore efforts at rehabilitation are being prevented by a severe economic crisis that the country is undergoing. Generally the conditions of the Guyanese aboriginal

peoples are gradually improving from the miserable conditions of five and more years ago. There is some improvement in the national economy. Besides, there is amelioration coming from projects coinciding with the structural adjustment programme and the work of international agencies, church organizations, and local NGO's.

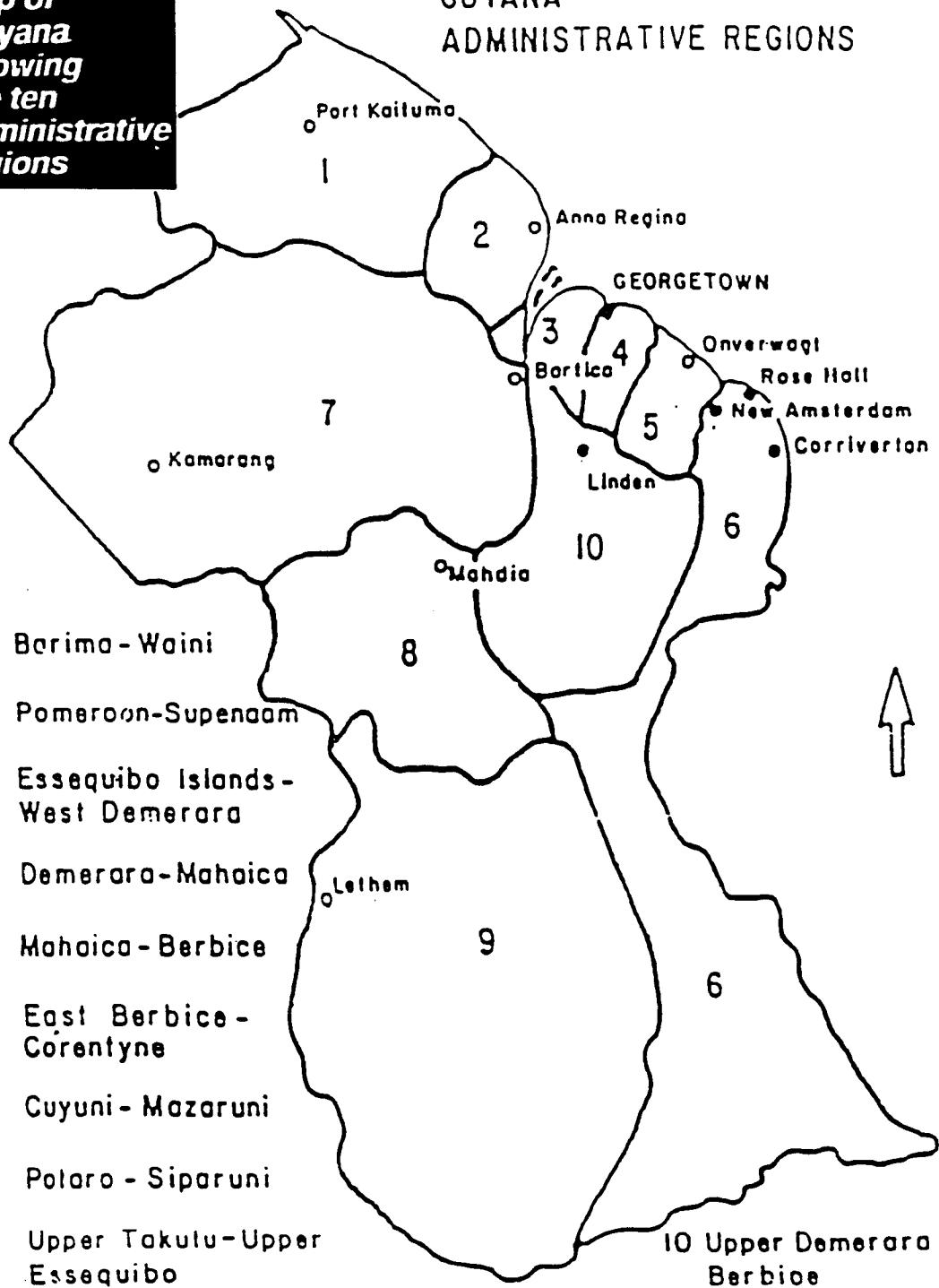
The country which has suffered the least political and economic shock within the past decade is Belize. The steady economic growth has translated into tangible benefits in social services, including health. One of these is a growth in epidemiological studies enabling a more accurate stratification between aboriginal peoples and the rest of the population in infant mortality rate and the high incidence of infectious diseases, and nutritional deficiencies. The studies also point to some aboriginal peoples being in worse conditions than others.

The Belize case undergirds the need to focus on the larger context within the state as being crucial to understanding the health conditions of aboriginal peoples. The physical environment, health infrastructure, inaccessibility are all important. But they are symptoms of the commanding forces of poverty, powerlessness, and the de-indigenization process the states are imposing on the aboriginal peoples. This study has maintained as its overall conceptual orientation the social, economic, cultural dimensions emanating from the state and impacting on aboriginal peoples.

The projects recommended include those that need to be implemented as a matter of urgency and in the medium term. They are described in Chapter V.

Map of Guyana showing the ten administrative regions

GUYANA ADMINISTRATIVE REGIONS



- 1 Berima - Waini
- 2 Pomeroon-Supenaam
- 3 Essequibo Islands - West Demerara
- 4 Demerara-Mahaica
- 5 Mahaica-Berbice
- 6 East Berbice - Corentyne
- 7 Cuyuni - Mazaruni
- 8 Polaró - Siparuni
- 9 Upper Takutu - Upper Essequibo
- 10 Upper Demerara - Berbice

INTRODUCTION

1.1 The Study - Scope and Methods

PAHO commissioned this study to report on the health situation of the aboriginal peoples of St. Vincent, Dominica, Belize, Guyana, Suriname and possibly French Guiana. Although the terms of reference is on "indigenous peoples", I prefer the designation "aboriginal peoples ". It refers to those sharing biological and cultural traits with peoples who were in the New World before Columbus. Being "indigenous" means "native to" a region but not necessarily sharing the specificity of Pre-Columbian origins. As we shall see in chapter 3 the case of the Maroons, who are indigenous to Suriname but not aboriginal, drives home this point.

Within a few months after the request for the study there was a need to make radical changes in the geographic spread and the scope of information to be collected. Belize posed relatively few problems for comprehensive fact finding since I reside here. Travel to the other countries, however, had to be curtailed because of limitations of funds. I was able to visit only two other countries - Guyana from August 10th to the 13th and Suriname from August 14th to the 18th, a total of nine days for both countries. The constraints on travel and access to data effectively limited the need to collect whatever I could on health and related social conditions of aboriginal peoples in Guyana and Suriname leaving aside French Guiana and the islands of St. Vincent and Dominica.

Apart from visits to Guyana, Suriname, and target areas in Belize, the methods of data collection included reviewing office documents and conducting interviews. Although my visit to Guyana and Suriname was limited to the capital cities, it gave me as close an opportunity as I could get to sense the larger social context that surrounds aboriginal peoples. Besides, I was able to review documents in offices and documentation centers, notably the PAHO documentation centre in Georgetown, Guyana. Most importantly I was able to interview several persons - most at short notice but still willingly allowing me to pick their brain. They were mostly medical practitioners and other health workers mainly in the government service. Others were researchers working for UNICEF, PAHO, OAS, government and academic institutions. I was also able to hold lengthy and brotherly discussions with aboriginal persons. Among my most interesting sessions were focus group discussions with aboriginal student teachers in Belize. Appendix 3 contains a list of the persons I interviewed.

1.2 The Report

Bringing together bits of hastily collected data into a reasonably sequential narrative on the state of the health of thousands in three different countries is a task that one does more from a moral justification to bring to light what would otherwise remain in the dark. The report focuses on some main social factors - i.e. cultural, social, and political - that constrain the health of aboriginal peoples. This framework is especially appropriate for three Third World countries sharing prolonged colonial history. Furthermore they are buffeted by severe economic crisis that severely limits what they can provide for the well-being of their citizenry.

The following chapter covers recurrent themes in the social landscape of the three countries. They include the primacy of government in health delivery despite its increased inability to do so due to cutbacks in public revenue; highly centralized political structures that leave no scope for decentralization; and the prevailing cultural pluralism that confines aboriginal peoples to the bottom of the hierarchical social ladder.

The third chapter is dedicated to the aboriginal peoples themselves. There is an attempt to extricate from the small literature available to me some ethnographic information about their current conditions, parameters of their health situation, and the historical precedent.

Most of the narrative is found in chapter IV which focuses on the individual countries. The order of presentation starts with Suriname, about which I was able to collect the least data but which depicts a country in the most severe economic and political crises. Guyana follows with a closer view on the social and health conditions of aboriginal peoples. Finally, there is Belize a country least in crisis and where the aboriginal peoples are in an improved situation relative to Suriname and Guyana. However, their conditions both absolutely and compared to their compatriots are far from laudatory.

Chapter V addresses the additional terms of reference in the assignment by focusing on two tasks. One is to do a profile of a health development project for the benefit of the aboriginal peoples of Belize. The other is to identify multicountry projects involving technical cooperation between countries. In the latter case I limit discussion to Suriname and Guyana.

1.3 Global Precedence

PAHO's objective for this study is to provide baseline data useful to solicit funding for proposals, which would address the health needs of the aboriginal peoples in parts of the Circum-Caribbean. It is in keeping with the renewed focus by PAHO on aboriginal peoples adopted in the fifth resolution approved at the 37th Meeting of its Council of Directors in 1993.

By focusing on the Caribbean PAHO is helping to break the deafening silence about this segment of the aboriginal population of the Americas. To a large extent the governments of the countries in the subregion have to take the blame in maintaining the non-recognition of their aboriginal peoples as distinct sociocultures with problems demanding specific solutions. The normal response of government ministers is that such recognition would be counterproductive toward national unity within microstates. However, this excuse has become transfixed into an ethic to deny aboriginal peoples the opportunities to mobilize thereby forcing them into a paralysis of inaction.

The marginalization of the Caribbean within the world aboriginal movement will cause the peoples themselves to lose the benefits of participating in a momentum that is assuming historic proportions. Within the wake of 1992 the following milestones have been achieved - the 1989 ILO Convention No. 169 - which admonishes states to grant special privileges to aboriginal peoples; chapter 26 of Agenda 21 of the World Summit on the Environment which advocates respect for the special relationships that aboriginal peoples maintain with their environment; a statement on the health of indigenous children in the UNICEF World Summit on children; and the April 20, 1994 statement by the Commission on Human Rights of the Economic and Social Council of the UN entitled "Discrimination against Indigenous Peoples". Finally, the World Decade of Indigenous Peoples 1994 to 2004 has just been declared by the UN to further galvanize the high level of attention that is needed.

Most pertinent to this study is the Winnipeg Declaration emanating from the Canadian Society for International Health (CSIH)/PAHO Gathering on the health of the hemisphere's aboriginal peoples held April 13 to 18, 1993. The participants discussed the concept of health found among aboriginal peoples which departs fundamentally from that held by the West. Basically it is a focus on the healing properties originating from the body, community, and mother earth within a seamlessness that places health as integral to human life. Discussions I had with healing practitioners in Belize confirm this orientation. I assume that it holds for the aboriginal peoples in the other countries .

The Proceedings of the Winnipeg Gathering includes the following as summary on the discussions on the second day,

"A long and persistent struggle will be needed to reclaim Indigenous Peoples' rights in the face of deceit, persecution, and a combination of legislative, regulatory, and bureaucratic traps. Only the ultimately non-negotiable objective of aboriginal sovereignty will put an end to a long history of rationing health care in a way that has made appropriate services inaccessible to Indigenous Peoples."

This level of political rhetoric - common in North, Central, and South America - is new to the aboriginal peoples in the Caribbean. The results of this study can lead the way to a questioning by the Caribbean aboriginal peoples how they can get caught up in a movement that may be passing them by permanently.

CHAPTER II

OVERVIEW OF THE THREE COUNTRIES

2.1 Societies in Transition

Belize, Guyana, and Suriname are three former colonies located on areas of the mainland considered strategic by Britain and the Netherlands in displacing Spain in the 16th and 17th centuries. Belize became independent in 1981 and after earlier alternating between Britain and the Netherlands, Guyana became independent in 1966 and Suriname in 1975. Belize is on the Caribbean coast of Central America at the southern base of the Yucatan Peninsula. Guyana is on the Northeast Atlantic coast of South America south of Venezuela. Suriname is immediately east of Guyana.

Being outposts of non-Iberian cultural heritage within Latin America is a trait that the three countries share. Another is a tradition of linking the delivery of social services, including health, within a highly centralized colonial system (R.T. Smith 1982:111-142). The colonial system itself was challenged by an aggressive anti-colonial popular campaign in the post World War II era but not the centralized delivery of social services. Indeed, it became a basis of the development process in the post-colonial period. In short, health care has always been a direct responsibility of the state and a fulfillment of its responsibility to its (colonial) subjects earlier and later its citizens. As such it has been a means of displaying conspicuous concern through large hospitals located in capital cities and health centers dotted in the countryside. On the other hand despite lip service at the policy level, there is little emphasis on primary health care and absolutely none on traditional practices of aboriginal peoples, among other small folk.

Since the 1950's the health profile has been in a phase of transition from a high prevalence of infectious diseases to a larger proportion of chronic diseases (see Appendix 2). The former are mainly childhood diseases, such as diarrhoea and acute respiratory infection and vector borne diseases, such as malaria. The chronic diseases are diabetes, hypertension and related cerebrovascular complications. Both infectious and chronic diseases are more prevalent in pockets of geographic isolation which include communities of aboriginal peoples.

Also undergoing another transition has been the demography in terms of falling mortality and morbidity and gradually lower

fertility resulting in a longer and relatively more healthy life for the population. Again, a lag in this is noticeable among aboriginal peoples.

To a large extent the success of the transition in health and demography has been the result of friendly foreign intervention. It arises mainly from perduring ties with the former mother countries which remain the source of large portions of the public revenue through preferential trade tariffs. Also pivotal has been technical assistance from the United Nations, notably WHO/PAHO and UNICEF and international NGO's. By utilizing these various assistance programmes the state and local NGO's have been able to offer free health care to all citizens.

But the 1980's and 1990's have witnessed severe cutbacks in the public revenue from falling commodity prices in the export market. Foreign private investment even from former colonial masters has been dwindling. The three countries have a limited industrial processing capability. Finally the possibility for base communities - where most aboriginal peoples live - to generate sustainable income generating activities remain more a potential. All this has brought these countries into another transition. It is characterized by reliance on an increasingly unfavourable international trade regime controlled by mega-blocks and growing protectionism. It makes health and social services more and more dependent on inputs from the UN agencies, bilateral funding from North America and Europe and international NGO's. It is especially the case in the two countries hardest hit by IMF imposed structural adjustment programmes - Suriname and Guyana.

In desperation to find alternative revenue sources and with little forward planning all three countries have within a few years negotiated large contracts with multinationals based in the newly industrializing Asian countries to exploit their ample forestry resources. Large portions of these concessions, however are adjoining lands traditionally occupied by aboriginal peoples. The delicate balance between humankind and nature that has been cultivated for millennia now faces a threat much worse than any beforehand. The perpetrators, the latter day "imperialist" exploiters, include MUSA of Indonesia for Suriname, BARAMA of Malaysia in Guyana, and another Malaysian conglomerate in Belize.

The all encompassing international economic world order leaves hardly any political space for minuscule developing countries like Belize, Guyana, and Suriname. Similarly there is hardly any allowance for political representation for aboriginal peoples among other small isolated groups within the countries themselves. While continuing the colonial legacy of being democracies, they retain highly centralized governments. There is little scope for regionally representative political structures; and even where they exist on paper as the Regional Democratic Councils of Guyana, they are sidetracked or

deliberately sabotaged by national political parties. Again on paper the political parties allow for membership of aboriginal peoples but in fact they exercise minimal power and are forced to abide by the patron clientilism that permeates partisan politics in their respective countries.

If the political parties have impaled the aboriginal peoples at the bottom in the post colonial era, it was the same position in which the cultural pluralism of the colonies had placed them for centuries. All three countries are remarkable for depicting levels of cultural pluralism rarely surpassed in small states. The inhabitants are descendants of human labour that colonial masters brought as they wanted from Europe (e.g. Portuguese), Asia (e.g. Chinese, East Indians, and Indonesians), and of course masses of slaves from Africa. Others came as refugees from adjoining countries. All the incomers were superimposed on the native inhabitants even as they died in large numbers only increasing consistently since the early part of the century. Furthermore the descendants of the incomers have been juxtaposed in a hierarchical structure closer to the colonial masters within a pervasive pattern of the non-validation of aboriginal culture.

2.2 Settlement Pattern

This overview would not be complete without a word on the settlement pattern that all three countries share. There are three characteristics - primacy of the capital city, the dichotomy between the Coast and the Interior, and the use of rivers as pathways to extend coastal influence into the Interior.

The capital cities of Georgetown (in Guyana), Paramaribo (in Suriname), and the ex-capital Belize City (in Belize) contain between one-third and two-thirds of the respective national populations. It is there that the headquarters of the church, educational institutions, industries, and voluntary organizations are located. Around such infrastructure the residents have attempted to re-create their little bits of the metropole that is not available anywhere else in the country. It is not surprising that out migration to the very heart of the metropole in the former mother countries has been excessive in all three countries. It is estimated that one third of the population of all three countries have migrated northward - mainly North America for Belize and Guyana and the Netherlands for Suriname. While earlier the capital cities were the major springboard for immigration, since the 1960's it has spread to other parts of the countries.

From the capital cities the main towns and villages spread horizontally along the Coast. Agriculture and some industries were located there before the discovery of minerals in large commercial quantities further inland in Guyana and Suriname. If the Coast is the place to be in lieu of immigrating, the Interior is the black box, the place certainly not to be. It is untamed, wild, full of bush, ferocious animals, and primitive Amerindians - a picture immortalized in several works of fiction (eg. Bradner 1981). The Coast and Interior are in fact two distinct societies joined by rivers of legendary sizes. Some examples are the Suriname, Demerara, and Essequibo.

Through the rivers inhabitants of the Interior traditionally received trade goods overtime generating a dependency that extends to essential foods, medicine, clothing, kitchen implements etc. The downriver traffic included woods, rainforest extracts such as balata, food stuff, handicrafts; as well as people who no longer wanted to remain in the darkness of the Interior. Within the past thirty years aircraft traffic has increased but only to some locations and subject to highly inflated fares non-affordable to people of the Interior. Roads remain confined to the Coast apart from some treks passable during short periods of dry in the Interior. Boats therefore are still the umbilical cord joining the two regions.

Ironically, the relatively underexploited character of the Interior has become a two-edge sword. It has lacked development in the traditional sense of a headlong thrust into modernization. However, it has enabled a high degree of co-existence between the inhabitants and their environment, resulting in considerably slowing the degradation seen along the Coast. In a similar situation in neighbouring Central America Mac Chapin (personal communication) has shown that the only part of the isthmus where there is still some relatively large stands of rainforest is exactly where communities of aboriginal people are concentrated. As states look towards these new frontiers for massive exploitation, they are receiving international resistance from donor countries, development banks, and the strong "green" lobby. The resulting support that impacts directly on the cause of aboriginal peoples is overwhelming and calls for methods of interfacing that did not exist a few years ago.

2.3 Belize - A Special Case

A word about Belize which no longer shares the above pattern of settlement more characteristic of Suriname and Guyana in terms of the dichotomy between the Coast and the Interior and the excessive reliance on sea and river traffic. First of all, Belize is the smallest in land area of the three countries measuring only 22,965 in square kilometers in contrast to

Suriname's 163,265 square kilometers and Guyana's 214,970 square kilometers. While the bulk of the population lives not more than five kilometers away from the Coast in Belize, since the 1940's the government has embarked on an ambitious road programme that has eventually linked all the district towns and almost all the villages apart from a few in the deep South. As a result Belize has developed a much more comprehensive network for the delivery of social services, including health. The other countries are from achieving this goal.

2.4 Summary

The following is a summary of the overview of the three countries. Health delivery is a prerogative of the state's overall development programme. Its emphasis, however, is on high profile intra-mural services set in hospitals and clinics in cities and towns. Primary health care has received little more than lip service and there is no focus on traditional health practices. The current political economy can add hardly any improvement. The economies of the three countries are being buffeted by the need to adjust to hostile global re-alignments and already all three are experiencing slow economic growth. Besides, the political structure while conforming to shades of western democracy is highly centralized with little provision for any decentralization. Finally, there is superimposed on an extensive cultural pluralism a highly integrationist policy that leaves hardly any space for the autonomy of aboriginal peoples but instead seeks to de-indigenize them within the national creole (i.e. hybrid) milieu.

The silver lining that augurs well for some improvement in the disposition of the state toward aboriginal peoples is the increasing international awareness of the bounty of the rainforest including the patterns of co-existence in which the aboriginal peoples have traditionally been leaders. However, this calls for renewed methods of articulation in which the aboriginal peoples will have to take the lead.

There is now a need to focus more especially on the aboriginal peoples themselves. It is a topic of the following discussion.

Chapter 3

The Aborigines

3.1 Who They Are

In a way it is a miracle that there are people in the Circum-Caribbean who still identify themselves as being aboriginal. These are groups that retain an historical consciousness of their ancestry as far back as the people who were in the region before Columbus. The consciousness receives its strength from cultural traits and biological features. Chief among the former are food items and other uses of the flora and fauna, the hand production of several utilitarian items, religious rituals, and healing practices. Because biological features are so heavily value laden within the highly race conscious Caribbean their significance as markers for aboriginal peoples is weak. However, such features as wide cheek bones, skin colour, hair texture, short stature coalesce to varying degrees among aboriginal peoples. The question, however, still remains how people still self-identify despite all the efforts of mass extermination during the past 500 years in this the first area of impact between Europeans and the natives of the New World.

The answer to this question leads to a brief investigation of the aboriginal roots that the peoples share. There are two macro-traditions found among aboriginal peoples in the three countries - the Amazonian and Mesoamerican (Eckholm & Willey 1966 and Rouse 1966). In Suriname and Guyana they are the Amazonian (Lowie 1948 and Steward 1948). In Belize the Mopan, Yucatec, and Kekchi (See Appendix 2) share the Mesoamerican and the Garifuna the Amazonian. Macro-traditions are anthropological categories for major linguistic groupings together with other cultural diagnostics.

People do not always fit into neat categories; and this is especially so in the Caribbean where extensive intermixing limits the exclusivity associated with categories. An extreme example is the Garifuna. They are now found in Belize and neighbouring Central American countries but were formed in the East Caribbean island of St. Vincent from a mixture of maroon African slaves and Carib Indians (Gonzalez 1988). The interesting aspect of Garifuna culture is the high level of its aboriginal component. It is not the case in other examples of admixtures between aboriginals and non-aboriginals. As a matter of fact, the societal norm more often deliberately downplays the aboriginal, given its lessened rank within the prevailing stratification

system. Finally, there are the several cases of intermixture across aboriginal peoples which occurs widely in Guyana among the Arawaks, Warau, and Caribs in the northwest. What nation do the persons resulting from the mixture identify with? Is it possible to classify oneself as aboriginal without necessarily affiliating with a particular nation?

These and other questions are adding to the conundrum of cultural classification currently affecting an increasing number of persons. Unfortunately the pressure to exit from the confusion thereby de-classifying oneself as aboriginal is overpowering to most persons.

In Appendix 1 there is a breakdown of the nations and numbers within the respective countries. Even before discussing the significance of the numbers, it is necessary to say a word about their source. In all the countries except Belize the figures are approximations even for the country population. To a large extent the difficulty may be administrative, i.e. putting together a machinery to do head counts. More particularly for aboriginal peoples there is also the ideological context - the tendency to undercount or overcount. For example, I took the breakdown for Suriname from a statement delivered by the aboriginal leader Richard Pane at an international forum. Other sources in Suriname usually mention four nations and throw in a miscellaneous group for the others. The relative insignificance of head count for peoples who are in severe crisis is an indication of neglect by their respective governments.

We cannot end this discussion on cultural categories without referring to the Maroons in Suriname. They were keys to the exploitation of resources - timber, minerals, real estate speculation - in the Surinamese hinterland during the last century (Price ed. 1973: 293-398). They knew the lay of the land; had the means of transportation on the numerous waterways; and provided the labour. The relative independence of the Maroons to combine their lifeways with those of the Europeans without losing theirs stems from a strong social organization based on matrilineal clans grouped under six different nations. As the numbers of the aboriginal peoples diminished over time and their social organization fragmented, the Maroons were able to insert themselves into the resulting vacuum.

The cultural roots of the Maroons derive not from the New World but from West Africa. But over 300 years they have built a society fully established within the Surinamese hinterland. In short they are indigenous to Suriname.

The significance of the Maroon case is to highlight the primacy of cultural heritage as the sine qua non of aboriginal identity. The aboriginal heritage that is emphasized in this study is that of the peoples in Suriname who share the Amazonian

macro-tradition. A change in the terms of reference would have been needed to include the Maroons. It is interesting to note, however, that there is some affinity between the aboriginal peoples in Suriname with the Maroons, best seen in that both were fighting the state army as their common enemy during the six-year guerrilla war. The lessons to be learned here are twofold. One is that the social system within the state is important as a parameter to determine interaction among aboriginal peoples and between them and others. The other is that aboriginal peoples need to become aware of others within their respective states who are in similarly deprived conditions and could serve as useful allies.

3.2 What They Are

There are several nations found in the three countries. Appendix 1 shows that Belize has the largest proportion, almost 18% of the national population. Coming far behind is Guyana with 5.4% and Suriname with 2.1%.

Before elaborating on the "what" of aboriginal peoples we need to revisit the theme of cultural categories. Earlier we discussed what keeps aboriginal identity current by focusing on roots, the intermixture, and the special non-aboriginal identity of Maroons. The emphasis now shifts to the loss of traditional culture also called acculturation. Probably more than beforehand it is a major issue affecting the future of aboriginal peoples in the three countries.

The degree of acculturation overcoming all the nations is usually associated with living in the towns or closer to them in Belize and the Coast in Suriname and Guyana. It has become highly noticeable within the past thirty years as thousands no longer speak their language and have adjusted almost completely to an urban lifestyle complete with a career, a home, and firm determination never to return to the ancestral village. Furthermore they may also deliberately identify themselves as non-aboriginal, although their parents may do so, and their grandparents certainly had no other choice. Examples of such transformation are found among the Arawaks and Caribs who live closer to Georgetown in Guyana; the Yucatec and Garifuna in Belize; and the Arawaks in Suriname.

These changes bring into perspective the other extreme - peoples who are less acculturated, speak their language; and still engage in significant aspects of their traditional culture. The examples are becoming fewer. They include the Wai Wai of Guyana and Kekchi in Belize.

The need to emphasize the wide range of cultural identification is to draw attention to two points. One is the fact that the figures in Appendix 1 are approximations most probably on the lower side. The other is the constant evolution among the peoples in the three countries toward non-identification. The miserable conditions in which they find themselves are certainly no incentive to positively self-identify, when other options are available "to pass" into the cultural mainstream of their respective states.

POVERTY is the one word most appropriate to describe their current conditions. It has economic, political, and cultural dimensions.

Economically most are a rural proletariat. They are basic manual labourers dependent on jobs in the timber industry, agroforestry, mining, and whatever else is available in the hinterland. It applies to a less extent in Belize where the Yucatec but also some Mopan and Kekchi are peasant agriculturalists and contribute significantly to the country's internal food consumption and foreign commodity market. They use their own land or reservation lands on which they have usufruct rights. It is predictable that with the phasing out of preferential tariffs for agricultural products from the EC market by 2005 the aboriginal peoples of Belize will be reduced to the same level of poverty as their counterparts in the other two countries. This certainty will only be mitigated by strategic economic planning in which the government of Belize is currently engaged (see the National Plan for Action for Human Development).

In all three countries there is greater reliance on the cash economy as they grow only minimally for their own food needs. But the job situation and the markets are precarious. In such scenario women are greater losers. There are even fewer jobs available to them. The traditional cottage industries of handicraft making and sewing are limited. Increasingly both men and women see their future away from their communities and in neighbouring towns, the capital city, or abroad.

Ultimately decentralization is the only way that could lead to some redress to their economic conditions, especially if it means some control of their land and the natural resources within their informal domain. To arrive at this there is need for regional government administrations responding to political directives coming from the aboriginal peoples themselves. At present it is a farfetched dream in the three countries all of which have highly centralized administrations controlled topdown by politicians with a nationally partisan agenda. Furthermore the civil society - i.e. labour unions, voluntary organizations, etc, - already show little sympathy toward their cause and would do

much less should they make any effort to claim autonomy for themselves. For similar response in other countries see Benjamin and Tiessen 1993:(252-261).

A brief overview of their history shows overlaps within the three countries that have conditioned the current situation of the aboriginal peoples and their response. Throughout history the aboriginal peoples were main agents of the colonial masters in carrying out their designs. For more information see Menezes 1977, Sanders 1987, Thompson 1987, and Whitehead 1988. In Guyana and Suriname they became the chosen subjects with the special mission to maintain security over slaves. In Belize the usefulness of the Yucatec came in the latter half of the last century when they were the first to engage substantively in peasant agricultural production in the colony (Dobson 1973).

The prized status of the aboriginal peoples was extended after slavery up to the end of the colonial era through the paternalistic patronage of the mother countries (Bolland 1987:33-76). The upshot is that they have found themselves as appendages within their respective countries, survivals of a colonial system that has become obsolete. The possibility of integrating within their states on their own terms now seems almost impossible. It is a vicious chicken-and-egg situation resulting from the extreme powerlessness of the aboriginal peoples and the overwhelming problems overcoming their respective states. Any breakthrough will come from a diametrical change in enlightenment among the powerbrokers in these states, a corresponding change in the strategies of the aboriginal peoples in dealing with them, and a great deal of moral influence forthcoming from the world community.

3.3 History, Culture, and Health

As late as the 1961 entire nations were still disappearing through a combination of intermarriage, migration, deculturation, and disease. An example was the death of Mary Koko of the Aoraoi nation in Guyana (Forte 1988:322-352). The generation born in the postwar era is the first to have the best chances of not becoming extinct solely through diseases. On the other hand, their chances of proliferating are much higher due to access to immunization and other basic health interventions. Collectively they owe a massive debt to the miracles of modern medicine.

From early in this century the colonial powers in their romantic commitment to mitigate the extermination of the "savages" (as well as to safeguard supply of cheap laborers) had undertaken studies of their diseases and had initiated specific treatment regimes during epidemics (see Forte 1988: 322-352). Such treatment made western medicine to the aboriginal peoples as

indispensable as gunpowder, blankets, and wheat flour. The corollary is that they became less reliant on their own systems of curing or retained only those aspects not available through western medicine. For example, among the Garifuna the dugu ceremony (Foster 1986) remains and has become more popular during recent years. The reason is that its centripetal forces draw kinfolk from distant places to engage in mass healing, particularly important to a people scattered long distances through labour migration (Palacio 1973: 3-8). Among the Maroons the skill of bone setting has become legendary throughout Suriname. The shamanistic practices of combining ritual with curing is used among the nations in all the countries. Efforts by the people themselves to retrieve these practices, including the knowledge of botanical pharmaceuticals, has not received the unequivocal encouragement of the governments. Ironically, colonial officers - for their own reasons - showed more regard in this area than political rulers in the independent states.

There are other reasons why aboriginal peoples are interested in western medicine. It is a career path for many. In all the countries CHW's are among the only persons in their communities receiving any cash from the outside, even if it arrives irregularly. Several boys and girls would like to become nurses and doctors as adults.

CHAPTER IV

The Country Reports

4.1 Introduction

This chapter covers the core of the study, the health of aboriginal peoples in the three countries. It starts by reviewing the general conditions on morbidity for each country and the health care delivery systems. These two factors provide a context for the health specifics of the aboriginal peoples.

4.2 Suriname

4.2.1 Mortality and Morbidity

In 1989 - 1990 Suriname recorded 7,966 deaths, of which 6,536 were certified. The following comes from 58% of those medically certified. Most of the information originates in the 1993 PAHO Report on Suriname Health Conditions. The first three causes of death in descending order are hypertension and heart disease, accidents and violence, and cerebrovascular accidents. The last three are pneumonia and influenza, chronic respiratory diseases and suicide. Appendix 2 gives a detailed breakdown.

The pattern depicted in Appendix 2 shows a mixture of chronic diseases such as hypertension and heart disease; infectious diseases such as gastroenteritis and respiratory infection; and diseases resulting from a basic breakdown in health care, such as perinatal deaths. The last one which is especially indicative of barely existing services refers to lack of regular check-ups during pregnancy and shortly after birth.

There is another cause of ill-health that makes Suriname outstanding among the three countries. It is dysfunctions within the society that breed an unusually high rate of accidents, violence, and suicide. They are no doubt a factor of the six year war between 1986 and 1992.

Two communicable diseases in Suriname are worth identifying. They are leprosy and tuberculosis. The former has lessened from 15.4 from 100,000 in 1990 to 14.1 in 1991 to 12.4 in 1992. The incidents of tuberculosis has fluctuated from 17.8 in 1990 to 11.6 in 1991 to 14.5 in 1992.

The above disturbing picture on overall health takes increased significance in spotlighting children. Between 1986

and 1989 there was hardly any noticeable improvement in the infant mortality rate. It was 20.6 from 1,000 live births in 1986, 22.1 in 1989, 20.9 in 1990. In 1991 it climbed to 38.0 (IDB 1993: 158). For children up to four years old gastroenteritis at 23.3 per 100,000 was the main killer. There has been a noticeable decrease in immunization coverage although the expanded programme for immunization started in 1976. In 1990 it was 53.6%, 1991 74.5%, and 1992 53.6%. Besides, only the following diseases were covered diphtheria, whooping cough, tetanus, and poliomyelitis. Transportation problems, and unavailability of vaccines were among the reasons for the decrease.

For children 4 to 14 years old malnutrition was a worsening problem. "In a 1989 study 11% of children were found to be undernourished (below the third percentile), while already 22.3% were measured for the first half of 1990" (UNICEF ND: 43).

The state of public health as described in the above dismal conditions was influenced by the availability of piped water. Here the Interior overshadows the Coast. Of the rural population along the Coast 70% has piped water. This figure rises to 95% of the actual urban population. On the other hand in the Interior the population uses only rivers and creeks - pushing into excessive proportions the incidents of gastroenteritis and other water borne diseases.

Furthermore a brief glance on the abuse of the environment within the Interior raises the larger issues of bio-diversity, not to mention the extensive dangers to human health. Topics include the unregulated use of pesticides and fertilizers, mining especially the use of mercury and other foreign matter in rivers that are used for drinking, crossborder practices including the illegal and totally environmentally abusive activities of Brazilian garimpieros in Suriname.

4.2.2 Health Care Delivery

Medical attention had always been a high priority of the Surinamese Government. One evidence has been the existence of a Medical School in the National University going as far back as 1887. There has also been a complex health bureaucratic structure headed by a planning unit that determines policy direction. Next in order of priority is the Bureau of Public Health which directs disease control programmes against malaria, yellow fever, and dengue. Maintaining responsibility for health care delivery to the public are the Regional Health Service (RGD) and Medical Missions (MZ).

"The RGD was established in 1980 with the task of implementing integral primary health care services for the poor along a 400 kilometer long and 50 kilometer deep coastal plain. It serves about 105,000 people with a special card of the Ministry of Social Affairs and roughly another 40,000 covered by State Health Insurance" (PAHO Suriname Report: 54). The health delivery system of the RGD consists of forty-five auxiliary posts in villages serviced by visiting doctors and nurses. It has 29 basic poly clinics offering medical, pharmaceutical and well baby clinics together with 9 health centers that in addition provide laboratory services and some hospital beds for emergencies. Finally, there are six hospitals in Paramaribo and one in the provincial town of Nickerie.

The Medical Mission concentrates its services in the Interior inhabited predominantly by Maroons and aboriginal peoples. Started over 200 years ago, it now combines the operations of three religious missions - Roman Catholics, Baptist, and Moravians. It operates 44 polyclinics manned by Health Assistants who originate from the local communities. It also maintains a 100 bed hospital in Paramaribo. The strength of the Medical Mission is in penetrating the Interior and including local health workers on its staff. One of the directors admitted that during the crisis of the bush war when their doctors and nurses had to evacuate from the Interior as much as 85% of care was provided solely by community health workers. He added that the plan was to integrate them even more into the organization, which would become more decentralized as the Medical Mission undergoes its postwar rehabilitation.

4.2.3 Health Within a Crisis Mode

Briefly, the crisis surrounding health care in Suriname is the lack of public revenue to acquire basic supplies and pay for the staff necessary to maintain what is on paper a comprehensive scheme. The government is saddled with large fiscal deficits arising from huge external debts. There is growing discrepancy between official and parallel exchange rates for hard currency leading to sky-rocketing inflation. The main export is aluminium which has been decreasing in price. The next export item is rice but it cannot provide the necessary foreign exchange. The available sources of foreign finance have narrowed and now are almost entirely reliant on aid, grants from the Netherlands, multilateral and bilateral development funds, and short term credit lines from countries such as Brazil, China, US and Venezuela (IDB 1993:158-163).

From the economic viewpoint the crisis in Suriname is no different from that in Belize, Guyana and other Third World Countries. With global cutbacks for primary commodities there is a need to restructure the methods of production to remain afloat in the new economic order. A firm political structure is a prerequisite to undergird the buffeting that such countries are undergoing and it is precisely in this regard that Suriname is most weak. Although it is nominally a democracy, it lacks a tradition of political representation that crosscuts its several ethnicities. There has been a strong tide of unrest since independence resulting in several military coups and a six-year guerrilla war. Together these have destroyed infrastructure and production especially in the Interior while displacing thousands - mostly Maroons - first in French Guiana and later in the general area of Paramaribo.

Military confrontations ceased in 1992 when the combatants signed a Peace Treaty. Whether this will result in an improved context for health among other social benefits will become somewhat clearer in discussing briefly the terms of the Peace Treaty further below.

4.2.4 Health Specifics of Aboriginal Peoples

I was unable to collect specific data for the aboriginal peoples of Suriname as was possible in Guyana and Belize. It is possible to make generic conclusions that the conditions are much worse in the Interior than what I have described earlier for the country (which actually was more relevant to the Coast). The traditional lag in the Interior was, of course, worsened by the almost total breakdown in the services of Medical Missions. One of the aftermath was the resurgence of malaria in epidemic proportions.

I was able to glean some relevant information from references to a survey on the socio-economic conditions in households in two communities in the Coast, a neighbourhood of Paramaribo and one 30 kilometers away. The PAHO Report (pg.25) refers to the study which was done in 1992 by the Division of Public Health in the Medical Faculty of the University. Another source was a funding proposal drafted in 1993 by Stichting Sanomaro Esa (Mother and Child in Arawak and Carib respectively), a local NGO.

The socio-economic survey concentrated on Creoles, Maroons, Hindustani, and Indonesians. The Maroons had the worst health indicators in immunization and overall living conditions. This was further correlated with relative status within Suriname's well delineated socioculture especially in terms of language. Being non-Dutch speaking the Maroons had fewer opportunities

available to them in most urban amenities from job to housing to health care.

In preparing its funding proposal Sanomaro Esa did a survey among aboriginal peoples living the furthest distance of 50 kilometers from Paramaribo. They found out that the children suffered from the following - intestinal parasites, skin rash, scalp irritation, and head lice. Besides, the women had low level of awareness about their health and their vulnerability to sexually transmitted diseases.

4.2.5 Peace Treaty - Framework for a New Beginning?

It is interesting to note that the immediate restoration of health services in the Interior was one of the terms of the Peace Treaty that was signed by the government, the Jungle Commando (signed by R. Brunswijk), and the Tucajana Amazonas (signed by T. Salbaho). Other areas specified were transportation, infrastructure, educational facilities, and social security. All of these were placed within a comprehensive framework of equity for the inhabitants of the Interior viz-a-viz other Surinamese. The instrument to achieve this goal would be a "Council for the Development of the Interior" to be constituted as part of the Peace Treaty.

There were other provisions that are familiar within the global struggle of aboriginal peoples. They include holding public discussions on ILO Convention 169, the Right to Traditional Lands, including the hand over of formal titles, and the recognition of traditional leadership structures.

However, the guerrilla war had not been one fought by aboriginal peoples to revindicate wrongs meted to them for centuries. They were caught within the frenzy of a prolonged military Commando operation headed by a Cuban trained military leader R. Brunswijke, who is himself a Maroon. Reasons for the participation of Arawaks, Caribs, and other aboriginal peoples seem even less for their own welfare than the strength of a "Marxist" ideology espoused by a few of their leaders. As a result, specific cultural issues such as healing practices, religious rituals, sacred locations, community organizations etc. did not receive the emphasis they rightly deserve. It was a commando group amnesty to "settle old scores", references to social amelioration being secondary. The focus on health stems, therefore, from an awareness of its desperate need, having fallen from what had been a publicly recognized standard of achievement. Apart from reinforcing this awareness on health, the peace treaty spelled out very little for the overall well-being of the Maroons and aboriginal peoples of Suriname.

4.3 Guyana

4.3.1. Mortality and Morbidity

The Health Statistics Unit of the Ministry of Health reported 4652 deaths in 1990. The first three of the ten leading causes were cerebrovascular disease, ischemic heart disease, and diseases of the pulmonary circulation and other forms of heart disease. The last three were certain conditions originating in the perinatal period, intestinal infections, and other accidents. The information found in Appendix 2 originates from the 1993 PAHO Guyana Health Conditions report.

As in the case of Suriname chronic diseases take precedence with a high proportion in the incidence of cerebrovascular diseases, heart disease, and hypertension. Also worthy of note is the relatively high proportion of conditions originating in the perinatal period.

While the broad causes of mortality are based on the quality of life, a review of childhood mortality reveals deficiencies in the delivery of health care, in water and public sanitation, and in the socioeconomy at the level of the household. The leading cause of death for children less than one is conditions in the perinatal period. It was 30.9% from a total of 525. The next was intestinal infections, which was also the leading killer for those between one and four. Undernutrition was the third major cause of death for infants less than one and the leading cause for those between one and four. Furthermore, 22% of children under five were underweight and 9% of those in the 12 to 23 months age range had wasting with 21% of those in the 24 to 59 months group showing stunting (Guyana PAHO: 15-22).

Finally, it is necessary to refer to societal disintegration as a cause of death in Guyana as we had observed in Suriname. Among one to four year olds homicides and injury inflicted by others, accidents, and other violence combined to account for 15% of all deaths in 1988 and 9.4% in 1990 (Guyana PAHO: 15-22).

Between 1986 and 1992 malaria was the leading cause of morbidity. Other leading causes of outpatient care from eight of the ten regions were hypertension, respiratory infections, diabetes, diarrhoea, worm infestations, arthritis, and anaemia.

4.3.2 Health Care Delivery

Since 1966 the Ministry of Health has provided free medical attention at several levels while private practitioners provide services for a fee. The Guyana Agency of Health Sciences, Education, Environment, and Food Policy (GAHEF) provides training for health personnel.

The first level of health care found primarily in the rural area is the community health post. There the Community Health Worker (CHW) provides simple treatment for basic ailment and makes referrals to the second level, the health centre. Health centres are found in more densely populated areas. The staff complement includes a medex (nurse practitioner) or public health nurse, nursing assistant, dental nurse, and midwife.

The health centres make referrals to the district hospital. It services an area of about 10,000 inhabitants providing the following services - simple surgery, medical and pediatric care, obstetrics and gynecology, and simple radiology and laboratory. Other services may include preventive health and dental service. The third level, regional hospitals, provides more complicated secondary services. At the top of the pyramid there is the national referral centre, the Georgetown Hospital.

The operation of the above structure has deteriorated considerably within the past three decades. Its almost complete breakdown among aboriginal peoples in the Interior will become clearer further below.

4.3.3 Health of Aboriginal Peoples

The following information comes from the "Situation Analysis of the Situation of Children and Women in the Guyana Amazon", a study that the Amerindian Research Unit of the University of Guyana did for UNICEF and released in September, 1993. The study analyses primary data on education, health, and agriculture collected in eight out of the ten administrative regions focusing on the welfare of women and children. The fieldworkers themselves were aboriginal persons. Apart from survey data they collected the impressions of teachers, missionaries, and others who had worked for years in the villages.

Malaria, tuberculosis, diarrhea, and respiratory infections are the four diseases that wreak havoc among aboriginal peoples. Separately anyone further weakens the body making it susceptible for other diseases. By 1992 fully one-third of the aboriginal persons were afflicted with malaria with an almost certain increase by 1994. It was at first concentrated in the Rupununi and then moved north and northwest. At least 60% of the cases are falciparum, the more dangerous variety. The men are more susceptible accounting for 70% of the cases as a result of having to migrate for job opportunities.

The surveillance for malaria is more comprehensive than for other diseases, such as tuberculosis. An indication of the extent of the latter is more impressionistic. One example comes from a neighborhood in Georgetown, where 17.5% of the cases were found among aboriginal peoples although they made up only 5% of

the population. Even this was most certainly an undercount.

Diarrheal diseases affect the entire population especially younger children. It stems from drinking impure water which almost all aboriginal communities are forced to do. Creeks, rivers, and wells are their predominant sources of water which are contaminated from the lack of latrines and other methods of waste disposal. Seasonality in the level and kind of water brings bouts of diarrhoea, dysentery, and related diseases. Another disease with its own seasonality, although not water related, is acute respiratory infection. The most vulnerable are young children and older folks.

The onset of cholera demonstrated the vulnerability of aboriginal peoples through a combination of adverse environmental conditions (reliance on rivers for drinking water), lack of public sanitation (use of rivers for waste disposal), and easy mobility (free transborder access) for trading and jobs. The bacterium is suspected to have crossed over from Venezuela. By 1993 there had been 617 cases with ten deaths. The relatively few deaths resulted from the quick reaction of the government in 1992 to stem the epidemic from spreading to the rest of the country's population.

The following conditions have less impact on aboriginal peoples, although, they are no less deserving of urgent attention. They are dental caries, snake bites, substance abuse, scabies, head lice, and HIV/AIDS.

Community Health Workers provide the only form of medical attention that the vast majority of aboriginal peoples receive in the Interior. Since the inception of their training in 1979, 182 CHW's have been trained and of these 85% continue practicing. The relatively high retention rate stems more from their personal interest as individuals. The overwhelming obstacles they routinely face include prolonged delays to receive their stipend, chronic lack of medication, political interference from regional party representatives, and lack of support from their supervisors.

The heroic efforts of the CHW's contrast with the inability of the government to service the Interior with basic health needs. The Expanded Immunization Programme is one such example. In 1993 vaccinations for BCG, polio, diphtheria, and measles reached less than 30% of their target. Reasons include transportation difficulties, lack of refrigerators to store vaccines, and shortage of staff.

The vacuum created by the government has been addressed by several mainly foreign NGO's. Some of the main ones include the Futures Fund, the Beacon Foundation, PAHO, UNICEF, Red Thread, InterAmerican Institute for Cooperation on Agriculture, Canada

Fund, World Food Programme, St. John's Foundation, CIDA/Bahai partnership. There are also organizations that work through the several church missions in the Interior.

4.3.4 Regionality and Health

Vast distances over uninhabited territory makes regionality a major determinant of well being in Guyana. Proximity to the Coast and more particularly to the area of Georgetown generally means greater access to the government health services stemming from easier transportation. On the other hand, greater distance translates to decreasing availability of indispensable resources including foods, household items, and medication; varying degrees of attempting to complement the sources of cash with the subsistence economy; and a greater two-way traffic with the neighbouring countries of Venezuela and Brazil. The following descriptions, which are taken verbatim from the "Situational Analysis of the Status of Women and Children in the Guyana Amazon", provide more detail. The areas are of increasing distance from Georgetown (see map).

The first excerpt comes from Region 5 which faces the ocean and lies between Georgetown and New Amsterdam. The aboriginal inhabitants are primarily Arawaks. The quotation refers to the community of Moraikobai surrounded by five satellite villages. The health profile is reported as follows,

"Women and children in the main attend the health centre in this village. Their complaints are similar to those reported of other Amerindian areas - common cold, diarrhea, etc. People also complain of scabies. Worm infestations are very common. Contraception is unavailable.

"The Regional Health Officer has visited on occasion, usually when other Regional administrators visit the village. In this village also there is perennial shortage of drugs. In recent years, however, the village has benefitted from drug donations from the Beacon Foundation, YCI and private visitors.

"Here also children between the ages of 2 and 5 years old suffer from mild degrees of malnutrition. In the words of the primary data collector. "Children suffer from malnutrition but this is looked upon as normal since they outgrow this as they get older. No child has suffered from this condition so as to die."

"Malaria: No cases are reported from villagers who stay only in the area. All malaria patients contracted the disease when outside the village, usually returning with malaria from the 'gold bush'

On diet,

"Cassava is grown and processed by almost all households but rice and flour also are used widely. The diet is reportedly not balanced and is predominantly of carbohydrates.

"Alcohol is present and consumed by both sexes. If there is no manufactured liquor, people will consume piwari, a fermented cassava-based drink." (p.67)

The second excerpt is from Region 1, the northern most part of Guyana adjoining the Venezuela border and inhabited by the Lokono Arawaks. Although it faces the ocean, the Region is difficult to access from Georgetown. It, therefore, serves as an example of an area further away from Region 5 but not as remote as Region 9, the location for the last excerpt.

A description of the health profile follows,

"The Kumaka Hospital serves the entire sub-region except for Waramuri, 9 miles downriver, and Kwebana, 22 miles away on the Waini River. Both are medical outposts with resident medexes. Until the Mercy Indian Health Committees were set up by local initiative in 1992, no primary care at the community level existed. Apart from the great distances that area women and children in particular must travel to get to the Hospital (situated at the top of an incline as well), the lack of local CHW's has meant in practice that there is no network to record numbers of births and deaths, major health problems, or to disseminate information on recommended sanitation and nutrition practices.

"The hospital itself is generally described as a white elephant, publicly in the maiden speech made in Parliament by the Minister of Amerindian Affairs, a native of Santa Rosa. It has never had an administrator and the volume of work has not allowed the medex to keep adequate records. One result of this situation is that there is a better sense of health conditions in small villages staffed only by a CHW than in this large area. Sick persons are reluctant to stay in the hospital since no meals are supplied and no provision made for their families to remain with them to assist them.

"The hospital suffers from a lack of a water supply: it has 2 cisterns that technically could receive water from the roof in the rainy season but the gutters are all broken around the complex of buildings. The hospital has no well of its own nor pump. The health committees have taken turns at working voluntarily on cleaning the building and its surroundings on a weekly basis but no monies have been spent on repairing the termite-infested walls and floors of many of the buildings, the broken screens, etc. so that there can be little pride in the final result.

"The records kept by the hospital are poor. No information could be obtained on the main health conditions treated in

recent years though one worker opined that bronchitis was a common ailment. There are two clerical staff at present, neither with any training in record keeping. There is a high turnover of nurses from the coast and no trained nurses from this area have presented themselves for work." (p.38)

The third excerpt is from Region 9, the most remote from Georgetown and accessible mainly by air. The nations living there are Makushi, Wapishana, and Wai Wai. Their isolation from the coast and the easier access to their fellow peoples across the border in Brazil has allowed them a greater retention of traditional culture than found among other peoples in Guyana. However, their reliance on western medicine and consumer goods is just as high.

"Although the CHW programme is in operation, the delivery of health care in the Rupununi, as in all Amerindian areas is inadequate, given the needs of the residents and vastness of the land area of the Rupununi. There are two hospitals - at Lethem in the centre and Annai in the north. There are medexes stationed at the Aishalton and Lethem Hospitals and one at the Sand Creek Health Centre.....

"There has been a sharp increase in the number of cases (of malaria) recorded between 1990 and 1991 moving from 168.7 cases out of every thousand in 1990 to 374.6 out of every thousand in 1991.

"The Malaria Eradication Programme is headquartered in Lethem.

Some persons have been trained in microscopy but not all villages provide this service. The CHW's assist by taking smears of suspected malaria cases which can be sent to the microscopist. There is currently an upsurge in the number of malaria cases. Some 100 people, one half of the village, are stricken at Apoteri in the north, Malaria poses a special threat to pregnant mothers and infants." (p. 111).

Belize

4.4.1 Mortality and Morbidity

In 1990 there were 915 deaths in Belize. The first three of the leading causes were heart disease, conditions originating in the perinatal period, and diseases of the respiratory system. The last three were diabetes, diseases of the digestive system, and hypertension. The following discussion on mortality and morbidity

comes from "Trends in Morbidity and Mortality" from the November 1992 Assessment of the Food, Nutrition, and Health Situation in Belize done by the Ministry of Health in association with other agencies.

There are some patterns arising from an analysis of the trends in mortality. Firstly, there has been a downward trend in the total death rate within the past twenty years. By 1989 the death rate had decreased from 6.8 per 1000 inhabitants in 1970 to 4.2, a figure comparable to that of more developed neighbouring countries like Panama 4.0 and Costa Rica 3.8. The age specific mortality rate is quite revealing. It shows that for most age groups it has remained about the same during the 1980-89 period, except for the 0-4 years group which declined from 10.8 to 5.5 per 1000. "The information is very important since it may be indicating that the Ministry of Health effort to control infectious diseases such as diarrhoea, respiratory infections, and vaccine preventable diseases in this age group has certainly had a favourable effect on reducing mortality" (pg. 22). It has also accounted for a decline in the IMR from a high of 49 per 1000 live births in 1983 to 22.5 in 1990.

Respiratory and cerebrovascular diseases and hypertension have shown an increasing trend since 1983. Conditions originating in the perinatal period deserve special mention. They climbed from being sixth place in 1983 to being second in 1990. We have seen similar trends in the other two countries.

Between 1976 and 1988 chronic diseases as a group have increased relative to infectious diseases. These include hypertensive disease, endocrine/immune disorders, ischemic heart disease, cerebrovascular diseases, and malignant neoplasms. These same diseases were occurring in all the districts except Cayo and Toledo. Among the four leading causes for Toledo were intestinal infections, nutritional deficiency, other diseases of the respiratory system, and congenital anomalies. Toledo is the district with the largest proportion of Mopan and Kekchi.

Further below there will be more information on morbidity viz a viz aboriginal peoples. Here it is necessary to mention malaria, the one communicable disease for which there is nationwide surveillance. Since the 1980's there has been a resurgence. While the rate for the whole country is 16.6 per 1000, Toledo had the highest rate at 47.6.

4.4.2 Health Care Delivery

To a large extent the rather favourable picture on health in Belize relative to the other two countries stems from the existence of interconnected health facilities and a road network spreading almost evenly throughout the inhabited portions of the

whole country. There are 17 health posts, 34 health centres, and seven district hospitals. There is an overall rate of 1.8 health centres per 10,000 inhabitants. Ironically this rate is higher for the Toledo and Stann Creek Districts, two districts with some of the highest morbidity figures in the country. The geographical spread among the villages and the fact that the worst roads are found in these districts make health delivery inaccessible to many inhabitants, most of whom are aboriginal peoples. Mobile clinics and CHW's are the other efforts to reach them.

There are 149 CHW's scattered throughout villages from a total of 219 who have been trained. Seventeen are active in Toledo out of 45 who have been trained. The CHW's and another extension arm of the MOH, Traditional Birth Attendants (TBA"s), receive regular training.

Training of the other staff and sending patients to Mexico for attention not available in Belize are methods that the government uses to intensify its delivery. The flagship of the government's current focus, however, has been building the new Belize City Hospital thereby upgrading the highest referral level in the country. While this is laudable, it is to be regretted that primary health care, which remains the vanguard of intervention at the community level, has seen no increase in budget in recent years. "Primary health care is more dependent on foreign aid donors than other components of the health budget - 75% of capital expenditure and 40% of the recurrent"(Ministry of Human Resources 1994: 26).

It is necessary to mention another element in the Belize government's policy on delivery that does not seem to be so pronounced in the other countries. It is to pinpoint a particular region of the country that is most deserving than others for social services that include education, social and community development, and health. Toledo is one such example (see the preliminary draft of the National Plan of Action of Human Development). A recent study identified the Toledo District as the poorest in the country (Lewis 1994). It is to be hoped that it will capture the attention of NGO's as they re-direct their efforts toward national development.

4.4.3 Health Specifics of Aboriginal Peoples

The source of information on the health specifics of aboriginal peoples was wider in Belize than the other two countries. The following information comes from interviews and focus group research and the results of surveys conducted for the 1992 food and nutrition assessment and a sentinel site study in the Toledo district.

Interviews with public health nurses in the Toledo and Stann Creek Districts, where aboriginal peoples predominate, indicate differences in the main causes of morbidity. For the Mopan and Kekchi they are anemia and acute respiratory infection. For the Garifuna they are diabetes and hypertension. My initial reaction is that these impressions are guided by a demographic differential among the persons most making use of government health facilities. There is a large proportion of older Garifuna remaining there while younger men and women have migrated. On the other hand, it is possible that relatively more children among the Mopan and Kekchi are being brought for medical attention by their parents to the mobile clinics, health centres, and district hospital. Nonetheless the concurrence of opinions among health authorities on the ethnic correlation of diseases is strong enough to warrant further serious study.

From its survey data the 1992 Belize food, nutrition, and health assessment reveals patterns that single out the Mopan and Kekchi as having the highest rates of diseases among the ethnic groups of the country. It arises from the environment (eg. malaria), nutritional deficiency (shortages of Vitamin a and zinc and higher proportion of anemia), shortages of institutional support (eg. nurses and doctors), and of infrastructure (water and waste disposal).

The 1992 sentinel sites study conducted by UNICEF and the Central Statistical Office of the Ministry of Economic Development provides additional information. Using rapid epidemiological methods in twenty villages it collected large amounts of social and health data. The analysis reveals the extent of morbidity among aboriginal peoples and the worsened state of the Kekchi relative to the two other sets of aboriginal peoples in the district, the Mopan and Garifuna.

The results of the sentinel sites study start with the infant mortality rate (IMR) for Toledo compared to the rest of the country. The sentinel sites method uses information arising from interviews while the IMR - which we cited earlier - uses the government Registry figures. The latter has always been criticized for not being exhaustive since there is high probability of under-reporting, especially in remote areas like parts of the Toledo District. Given the possible errors that could also arise from interviews and the rather limited sample, the sentinel sites figures may also not be completely accurate. Together both methods at best indicate a range. The sentinel sites study arrives at an IMR of 68 per 1000 live births while the Registry figures arrive at 25 for the country. In short, Toledo has a far higher rate (possibly twice as much) than the rest of the country.

The core of the sentinel study is on the incidence of diarrhoea. There is a strong correlation with the availability of

suitable drinking water and the use of toilet facilities. Communities that use creeks and wells and not pumps had higher incidence. The main source of water for 38% of the Kekchi was rivers and only 7% for the Mopan. Among the Kekchi 5% use wells while 86% of the Mopan do so. With respect of toilet use 70% of the Kekchi do not do so while among the Mopan this figure is 37%.

Whereas there is the temptation to assume that this pattern points to a predisposition among the Kekchi for a less sanitary lifestyle compared to the Mopan. Further probing reveals additional information. The Kekchi are located further away from the main roads and are less accessible to the massive intervention and public education that the government and NGO's have mounted. Here we see a parallel situation to that in Guyana where access from the main centre of resources causes major lapse in the health conditions of the aboriginal peoples.

4.5 Summary

In all countries chronic diseases are gaining ground on infectious diseases but the pockets where the latter prevail correspond with the subregions inhabited by aboriginal peoples. The environment together with deficiencies in infrastructure and institutional support are some of the main causes. The result is that aboriginal peoples are far more vulnerable to diseases than their other compatriots.

Generally the basic infrastructure for health delivery is commendable in the three countries. It reflects a long standing commitment by their governments to health as a cornerstone of development. The problem arises from their maintenance during times of economic crisis affecting especially Guyana and Suriname. Secondly, primary health care, the frontline of the health establishment in contact with aboriginal peoples receives the least support from the government. On the other hand, its impact is most vulnerable to political interference.

The profiles reveal distinct patterns among the countries. Suriname is a country in severe political and economic crisis. Solving this while implementing comprehensive postwar rehabilitation is the key to improvements in health delivery. Unfortunately there seems hardly anything that the aboriginal peoples can do to accelerate this process. Guyana is also a country undergoing a similar crisis with a main difference - it seems to be at a point of permanent turnaround. But until then the main impact on health delivery to aboriginal peoples - as grossly limited as it is - comes as amelioration schemes from foreign sources to the structural adjustment programme. Finally, Belize does not suffer the same degree of crisis as Suriname and Guyana. However, it shares in the same patterns of diseases. The main contribution coming from the Belize study was the ability to

investigate additional sources of morbidity and the extent of differences among aboriginal peoples.

Chapter V

Recommendations on Projects

5.1 Introduction

The terms of reference of this study calls for two sets of projects - one for the aboriginal peoples of Belize and the other for those in any two countries. In the latter case I focus on Guyana and Suriname.

5.2 Belize

There are three projects that I envisage for Belize. One is for immediate implementation as a matter of urgency and the other two are more for the short and medium term.

5.2.1 Malaria Intervention

The study shows that malaria is reaching epidemic proportions among the Kekchi and Mopan in the Toledo District. Ministry of Health surveillance statistics reveal that while the rate for the country is 16.6 per 1000 for Toledo it is 47.6.

The exact method of intervention would have to be coordinated with the current government programme, which will dictate the content of the project proposal.

5.2.3 Applied Research on the Garifuna and Yucatec

This study has included much more information about the Kekchi and Mopan than the Yucatec and Garifuna. There are indications I received mainly through interviews that the health situation of the Garifuna needs careful scrutiny. Diabetes and hypertension are reported to be common diseases. Besides, their nutritional status, as shown in the food assessment survey, suffers from micronutrient deficiencies. This as well as other causes may lead to anemia which is also a condition relatively common among them.

With respect to the Yucatec I collected very little information. Both Yucatec and Garifuna are peoples who have had to adjust to urban living quite rapidly within the past thirty years. While not afflicted seriously by infectious diseases more common to the rural aboriginal peoples, they may be affected seriously by chronic diseases by virtue of changes in their diet

and other aspects of urban life. Besides, they are at a lower social class with the added economic problems of caring for their health needs.

The research should be taken along the lines of a situation analysis with specific recommendations for intervention.

5.2.4 Traditional Health and Community Health Workers

This project has two phases - to undertake an inventory of traditional health practices and to integrate the results within the training of CHW's.

So far there has been no comprehensive study on the health practices of the aboriginal peoples in Belize. The aim would be to collect and document rituals, information on the pharmacopeia, and belief systems. Heavily participating as lead researchers in this study would be the healers themselves working hand in hand with CHW's. It would facilitate the second phase, namely to train CHW's to become familiar with and use, when appropriate, traditional healing practices.

5.3 Suriname and Guyana

5.3.1 Immediate Intervention

There are four areas for immediate intervention for Suriname and Guyana. They are the alleviation of the malaria epidemic; a focus on the severe deficiencies in the food supply and nutrition for children at the point of weaning, school age children, and child bearing women; safe water supply in all aboriginal communities; and regular stipend as part of overall work upgrading for CHW's.

The project specifics for each one of these would have to be worked out. My findings reveal that they are the minimal targets needed immediately to reduce the high rate of morbidity and mortality among aboriginal peoples in these countries. Because both countries are neighbouring designing technical cooperation on these projects for their mutual advantage should not be too difficult.

5.3.2 Traditional Health and CHW's

(same as in Belize)

5.4 Final Word

The global thrust that I have maintained in this study

counters the project approach that I have taken in the above recommendations. Tackling the health problems of aboriginal peoples certainly calls for technical solutions. But the basic infrastructure for these are already in place. What is also encouraging is the large numbers of international agencies and NGO's that are doing more than heroic work. Indeed, a systematic coordination of all assistance - foreign and national - would go a long way to start to address severe problems from a comprehensive perspective.

A political solution for the health problems is even more needed at this time. It would have to be negotiated between the state and the aboriginal peoples themselves with the friendly participation of PAHO or some other highly reputable international body. The items for the agenda would include political autonomy together with a capacity for aboriginal peoples to engage in their own regional planning and monitoring. It is my hope that this study, coming after the Winnipeg Declaration, would be a first step in this direction.

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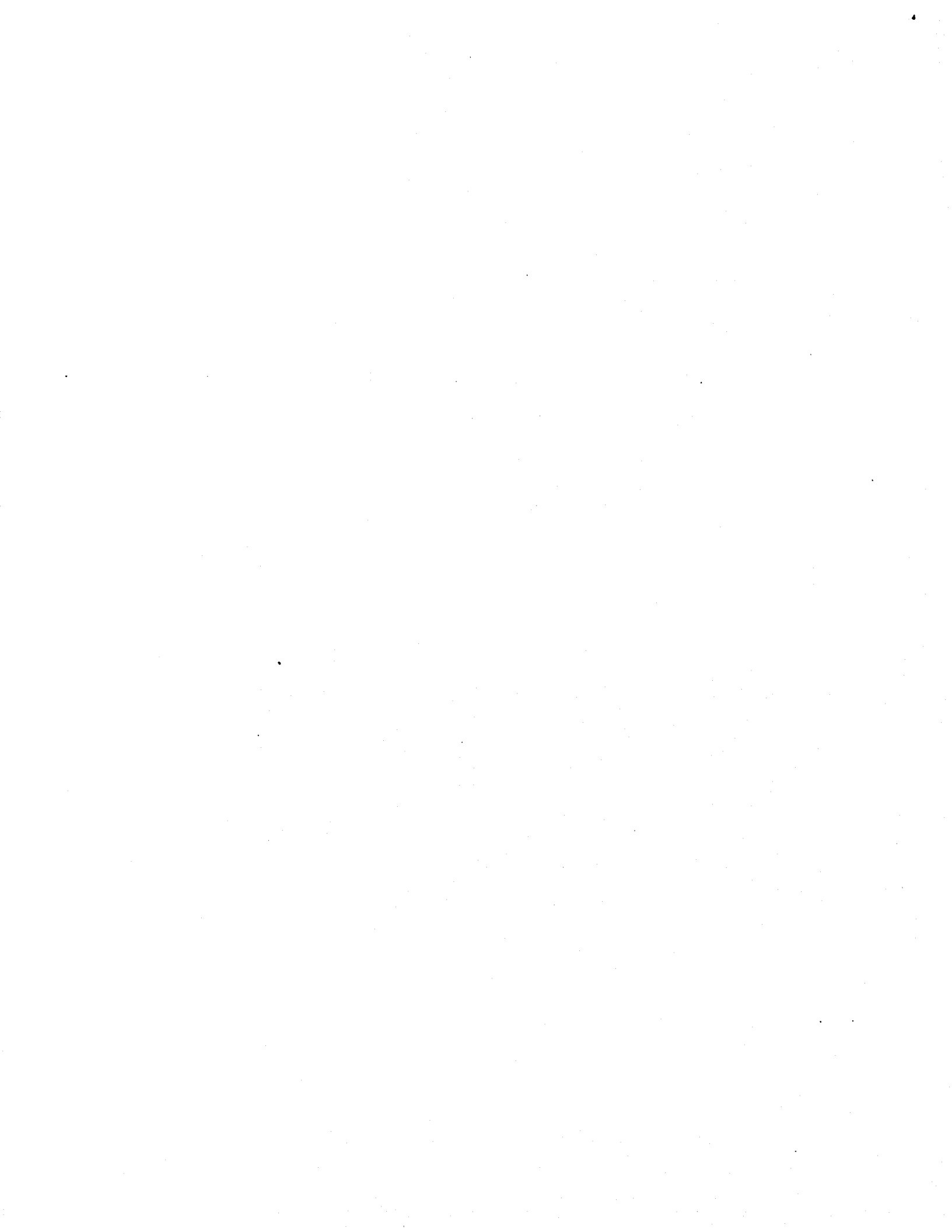
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Appendix 1

BREAKDOWN OF ABORIGINAL PEOPLES

Country Population	Aboriginal Peoples	No.	% Total Population
Suriname approx 1993 420,000	Kalina		
	Lokono		
	Trio		
	Wayana		
	Akurio		
	Warauw		
	Oiana		
	Wayorkule		
		8,820	2.1
Guyana approx 1992 737,945	Caribs		
	Warau		
	Arawak		
	Arekuna		
	Patamona		
	Makushi		
	Akawaio		
	Wai Wai		
		40,000	5.4
Belize approx 1991 184,722	Garifuna	12,274	6.6
	Kekchi	7,954	3.7
	Mopan	6,770	4.3
	Yucatec	32,684	17.7



Appendix 2

Principal Causes of Death

Country	Death
Belize 1990	Heart Disease Perinatal Diseases Respiratory System All Cancers Cerebrovascular Disease All Accidents (excluding vehicles) Motor Vehicle Accidents Diabetes Digestive System Hypertension
Suriname 1988/89	Hypertension & Heart Disease Accidents & Violence Cerebrovascular Accidents Malignant Neoplasm Perinatal Diseases Gastroenteritis Diabetes Pneumonia & Influenza Chronic Respiratory Infection Suicide
Guyana 1990	Cerebrovascular Disease Ischaemic Heart Disease Pulmonary Circulation Digestive System Endocrine & Metabolic Diseases Other Diseases of Respiratory System Hypertension Perinatal Diseases Intestinal Infections Other Accidents

APPENDIX 3

PERSONS CONTACTED

BELIZE

GOVERNMENT: Dr. E. Vanzie, Dr. R. Figueroa, Dr. P. Craig, Mrs. H. Cayetano

PAHO: Dr. V. Rathauser

OTHER: Ms. E. Jurgens and D. Warren of UNICEF. Ten first year students at Belize Teachers College.

GUYANA

GOVERNMENT: Mr. K. Davis, Dr. S. Gordon, Ms. C. Peters, Hon. V. De Souza

PAHO: Mr. P. Carr

OTHER: L. Pierre and D. Fox of the Amerindian Research Unit of the University of Guyana.

SURINAME

GOVERNMENT: Dr. L. Resida, Dr. C. Waterberg, Mr. R. Libretto

PAHO: Dr. M. O'Carroll

OTHER: Dr. J. Demiranda and Dr. Legiman of Medical Missions, Ms. H. Vreedzaam of Sanomaro, Mr. C. Healy of OAS.

