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Health of the Indigenous Peoples Initiative Progress Report

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Washington, D.C.



DIVISION OF HEALTH SYSTEMS AND SERVICES DEVELOPMENT
PAN AMERICAN HEALTH ORGANIZATION
WORLD HEALTH ORGANIZATION

HEALTH OF INDIGENOUS PEOPLES - RESOLUTION VI

THE XL 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 World's 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.)

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EXECUTIVE SUMMARY

Reliable epidemiological data on health and illness of the 43 million or more indigenous population of the Region of the Americas are not uniformly available. However, anecdotal information and a variety of studies support the need for renewed efforts to address the serious and pervasive inequities that exist in health status and health service coverage.

In 1992 the Subcommittee on Planning and Programming proposed a more careful consideration of the health and well being of the indigenous peoples in the Americas. Following a consultation workshop held in Winnipeg, Canada, with the participation of representatives of indigenous populations and governments and others from 18 countries, recommendations were incorporated into a proposal, the Health of Indigenous Peoples Initiative, which was subsequently presented to the Governing Bodies of the Organization and approved at the XXXVII Directing Council (1993).

The recommendations of Winnipeg and Resolution CD37.R5 establish five principles for work with indigenous communities; these principles guide the work, provide criteria for monitoring, and establish the basis for evaluation at the end of the Decade in 2004. They are: the need for a holistic approach to health; the right to self-determination of indigenous peoples; the right to systematic participation; respect for and revitalization of indigenous cultures; and reciprocity in relations.

Resolution CD37.R5 provides the framework for the efforts of PAHO and its Member States, in collaboration with the indigenous peoples themselves, to find realistic and sustainable solutions to the serious problems of poor health and substandard living conditions that are the reality of many of the indigenous peoples throughout the Region.

Work to date has been concentrated in the following five areas: building capacity and alliances; working with Member States to implement national and local processes and projects; projects in priority programmatic areas; strengthening traditional health systems; and scientific, technical, and public information.

In implementing Resolution CD37.R5 and the Initiative, a number of important lessons have been learned which will provide criteria for reorienting future work. Resource mobilization has taken longer than anticipated when the Plan of Action was developed in 1995. Tracking the interprogrammatic effort continues to be a challenge, especially when a more general project includes a component or activities related to indigenous health. Few countries routinely collect and analyze vital or service statistics by ethnic group, so it has been difficult to develop good baseline data for countries and to have an adequate assessment of health and living conditions of the indigenous peoples of the Region. Not enough progress has been made in the systematic participation of indigenous individuals and their organizations.

Based on the experience gained during 1993-1996, and in particular after two years of implementing the 1995-1998 Plan of Action, four principal areas of work are proposed for 1997-1998:

- strategic planning and management;
- priority programs;
- organization and delivery of health services in multicultural communities;
- production and dissemination of scientific, technical, and public information.

The Health of Indigenous Peoples Initiative is an opportunity to show that we are serious about the search for equity and the value we place on diversity, and it demonstrates our commitment to the goals of the Decade of the World's Indigenous Peoples. It encourages countries to detect and monitor inequities based upon ethnicity and to put programs and processes into place which will result in improved health status and access to health services for the indigenous peoples of the Americas.

As its 120th Session in June 1997 the Executive Committee reviewed Document CE120/17 and expressed concern for the inequities in health status of the indigenous peoples of the Region of the Americas and reaffirmed the commitment to the Health of Indigenous Peoples Initiative created by Resolution CD37.R5 in 1993. In consideration of the economic, geographic, and cultural barriers to the efficient and effective delivery of health services, the Executive Committee recommended that the Directing Council consider adoption of a resolution (CE120.R10, annexed) which addresses inequities as well as barriers to care, and which reaffirms the Organization's commitment to the goals of the Decade of the World's Indigenous Peoples.

INTRODUCTION

Reliable epidemiological data on health and illness of the 43 million or more indigenous population of the Region of the Americas are not uniformly available. However, anecdotal information and a variety of studies support the need for renewed efforts to address the serious and pervasive inequities that exist in health status and health service coverage:

- Mortality is 3.5 times higher for indigenous infants in Panama (Amaris et al., 1992).
- Twenty percent of indigenous infants in Bolivia die before 1 year of age and 14% of the survivors die before reaching school age (Asongs, 1986 in Cenda, 1993).
- National infant mortality in Chile was 17.1 per 1,000 live births compared to 20.6 in indigenous communities (UFRO, 1988).
- Mortality associated with diabetes was 166% higher for Native Americans (United States Indian Health Service, 1996).
- Infant mortality in Peru was 169/1,000 live births compared to 269 for indigenous populations (Masferrer, 1983).
- The 1990 age-standardized rate of death from accidents and violence for indigenous people is 81 per 100,000 population compared to 46 per 100,000 for the Canadian population (Minister of National Health and Welfare, 1992).
- Mayan school-age children in Belize showed the greatest growth retardation among ethnic groups (Government of Belize et al., 1996).
- In Honduras, life expectancy for indigenous men is 36 compared to 65 for all men and 43 for indigenous women compared to 70 for all women (Rivas, 1993).
- In Mexico, mortality among indigenous preschool children is 12.8% as compared to 4.8% at the national level (Instituto Nacional Indigenista, 1993).
- In Guatemala, the maternal mortality rate of the indigenous population is 83% higher than the national rate (Velásquez, 1994).

Countries throughout the Region are seeking new approaches to service delivery and innovative solutions to health problems for addressing the needs of these vulnerable groups. The problems reflected in this overall situation are intensified by the fact that there are more than 400 different ethnic groups in the Region, with a rich diversity of languages, customs, and beliefs, and this heterogeneity precludes the use of common approaches and interventions. However, a

cosmovision which emphasizes an integral view of health for individuals, and a focus on community and societal norms to protect biodiversity, have sustained these peoples over centuries of oppression.

In 1992 the Subcommittee on Planning and Programming proposed a more careful consideration of the health and well-being of the indigenous peoples in the Americas. Thus, in 1993, when the world celebrated the Year of the Indigenous Peoples, the Pan American Health Organization embarked on a joint venture with indigenous peoples to consider how PAHO should respond. Following a consultation workshop held in Winnipeg, Canada, with the participation of representatives of indigenous populations and governments and others from 18 countries, recommendations were incorporated into a proposal, the Health of Indigenous Peoples Initiative, which was subsequently presented to the Governing Bodies of the Organization and approved at the XXXVII Directing Council (1993).

At the global level, in 1996, the World Health Assembly adopted Resolution WHA49.26 on Implementing the Decade of the World's Indigenous Peoples, and the UN Working Group on Indigenous Populations, at its 14th session, included health as an agenda item. In both cases work under way in the Region of the Americas was acknowledged as having made progress in raising awareness about inequities in health status and access to care.

1. RESOLUTION CD37.R5

The recommendations of Winnipeg and Resolution CD37.R5 establish five principles for work with indigenous communities; these principles guide the work, provide criteria for monitoring, and establish the basis for evaluation at the end of the Decade in 2004. They are: the need for a holistic approach to health; the right to self-determination of indigenous peoples; the right to systematic participation; respect for and revitalization of indigenous cultures; and reciprocity in relations.

Resolution CD37.R5 provides the framework for the efforts of PAHO and its Member States, in collaboration with the indigenous peoples themselves, to find realistic and sustainable solutions to the serious problems of poor health and substandard living conditions that are the reality of many of the indigenous peoples throughout the Region. Member States agreed to establish technical commissions with indigenous representation, strengthen capacity of national and local institutions responsible for indigenous health, and implement intersectoral actions in health and environment in collaboration with indigenous organizations. For health systems and services, States proposed to develop alternative models of care including traditional medicine, and to develop disease prevention and health promotion programs for high priority problems.

PAHO, within the limits of available resources, was directed to promote the participation of indigenous persons and their communities, to mobilize additional resources for implementation and evaluation of the Initiative, and to coordinate the regional effort. Promoting collaborative research on high priority health issues and expanding the evaluation of living conditions and the health situation were also identified as key areas for concentrated efforts.

In 1994, participants in subregional workshops held in Santa Cruz, Bolivia, and Quetzaltenango, Guatemala, ratified the principles agreed to in Winnipeg and the goals of Resolution CD37.R5. By 1995, a Plan of Action had been established with the objective of ensuring that the political will expressed by the Member States in Resolution CD37.R5 was translated into concrete and sustainable action.

The goal of Resolution CD37.R5 is to support the indigenous peoples, governments, and other institutions committed to improve the health and living conditions of the indigenous peoples of the Americas through systematic and sustainable efforts, guided by the principles of the Indigenous Peoples and Health Workshop (Winnipeg, 1993) and, in so doing, to promote processes that lead to an improvement in the health and living conditions of all the peoples of the Region.

The purpose is to contribute effectively and efficiently to efforts by the countries and peoples of the Region to bring about an improvement in the health of indigenous peoples. This is to be accomplished through the identification, mobilization, and integration of appropriate resources, which will be used to activate, promote, support, and develop consensus-based and collaborative processes in the spirit of the Indigenous Peoples' Health Initiative.

2. PROGRESS IN IMPLEMENTATION THROUGH 1996

Work to date has been concentrated in the following five areas: building capacity and alliances; working with Member States to implement national and local processes and projects; projects in priority programmatic areas; strengthening traditional health systems; and scientific, technical, and public information.

The first area of work, building capacity and alliances, was the primary focus prior to developing the Plan of Action in 1995 and continues to be important as changes that need to be made in the Plan are identified on the basis of lessons learned in the first three years. Subregional workshops provided training, and promotion efforts identified key people in PAHO offices, in Ministries of Health, and in indigenous organizations who would be responsible for the implementation of Resolution CD37.R5. Alliances have been developed with international agencies, organizations and technical institutes. Table 1 provides a summary of the most important results of this effort.

Table 1. Building Capacity and Alliances

<p><i>Building Capacity</i></p> <p>Subregional workshops held in 1994 provided information about the Initiative and brought together PAHO staff, national counterparts and indigenous leaders to begin implementation. As of December 1996, 23 regional programs, 24 country offices and 17 Member States had designated someone to be responsible for the Initiative. In 1995 a work group prepared the Action Plan 1995-1998 and PAHO staff developed a work plan for 1995-1996, identifying the technical cooperation to be provided by PAHO.</p>
<p><i>Alliances with International Indigenous Organizations</i></p> <p>PAHO provided a grant to the International Indigenous Institute for a document on ethnic groups in the Americas. More is now known more about the 400 different ethnic groups in the Region. In 1995 PAHO signed a two-year agreement with the Indigenous Parliament of the Americas, forming the basis for an area of work in setting national policy and advocacy for indigenous health. By the end of 1996 the Indigenous Parliament had joined three other regional parliaments (Andean, Latin American, and Amazon) to work on common issues, including national policy and budgets for indigenous health and the regulation of traditional medicine.</p>
<p><i>Alliances with Banks and Other United Nations Agencies</i></p> <p>PAHO maintains close working relations with persons responsible for work on indigenous peoples' rights. Negotiations continue for funding to PAHO or to the countries for projects being developed. Representatives of the UN agencies meet yearly in conjunction with the UN Commission on Human Rights Work Group on Indigenous Populations. A common area of work for most of the agencies is indigenous knowledge. A number of joint activities have taken place.</p>
<p><i>Alliances with Institutions in Countries</i></p> <p>PAHO continues to maintain close working relations with the Canadian Society for International Health for advocacy and fund-raising purposes. The United States Indian Health Service of the Department of Health and Human Services is providing technical expertise in the evaluation of health and living conditions of indigenous peoples and in delivering basic services in rural, sparsely populated areas. The Office of Alternative Medicine of the U.S. National Institutes of Health is providing support for an inventory of traditional medicine.</p>

The second area of work, primarily supporting the countries' efforts to implement the resolution, is to enable the development of national and local plans, policies, and processes to benefit

the indigenous peoples of each country. Table 2 shows the estimated indigenous population for selected countries by total number and as a percentage of total population.

Table 2. Estimated Indigenous Population in the Americas by Total Number and as a % of Total Population in Selected Countries and Territories

Total Indigenous Populations			
%	<100,000	100,000 to 500,000	>500,000
More than 40%			Bolivia Ecuador Guatemala Peru
5-40%	Belize Guyana Suriname	El Salvador Nicaragua Panama	Chile Honduras Mexico
Less than 5%	Costa Rica French Guyana Jamaica Puerto Rico	Argentina Brazil Canada Paraguay	Colombia United States of America Venezuela

Sources: Inter-American Development Bank, Preliminary Project for the Creation of the Development Fund for the Indigenous Peoples of Latin America and the Caribbean, Washington, D.C., 1991. Inter-American Indigenous Institute, Data Bank, Mexico, 1992.

For this area of work a phased-in approach is being used for the countries of the Region:

Phase 1: Bolivia, Colombia, Chile, Ecuador, Honduras, Nicaragua, Panama

Phase 2: Guatemala, Mexico, Peru, Venezuela

Phase 3: Argentina, Belize, Brazil, El Salvador, Guyana, Paraguay, Suriname

Phase 4: The rest of the countries

All countries receive the benefit of subregional and regional efforts. From the beginning, the involvement of indigenous representatives, especially women, was a major concern. This work in countries has been facilitated through the active involvement of PAHO Country Offices and national counterparts in the ministries of health, when designated, as well as representatives of the indigenous peoples. Eighteen countries responded to a request for a report on progress; eight of the reports were prepared by representatives of ministries of health, and the other 10 were prepared by PAHO staff in the absence of an official response from the ministry. A summary of work under way in countries or planned based upon these progress reports will be published and disseminated.

The third area of work is to design and mobilize resources for projects which address priority health problems and vulnerable populations. Considering the recommendations from the indigenous communities through the ongoing consultative process, the Initiative has promoted projects and activities in a number of program areas. There are now 18 regional programs with proposals, concrete technical cooperation activities, concept papers, and extrabudgetary projects at various stages of development. Most progress has related to basic water and sanitation, indigenous women, cholera, vaccine-preventable diseases, and NGOs for health development.

A fourth area of work has been to develop and strengthen traditional health systems. Part of the challenge in this area is to find a better articulation between the indigenous health system with its multiple health agents and practices and the official system offered by governments. It is likely that a majority of the 43 million indigenous peoples in the Region have no real access to basic primary health care offered through government-sponsored programs. Where there is physical access there are often financial, geographic, or cultural barriers to the use of the services. These communities depend upon traditional and spiritual healers to promote health, prevent illness, and provide treatment for common conditions; they are often the only provider available on a continuing basis. There have been several intercountry projects where traditional healers learn from each other. Some countries have established NGOs of traditional healers to address needs for quality improvement and national recognition. Legislation is an aspect of growing concern as practitioners find it more difficult to practice or to continue to have access to the products they use for healing. In some cases the objective is to restore knowledge which has been lost because of a devaluing of the use of traditional practices in the past and the lack of interest by young indigenous persons in becoming a traditional healer. An important aspect is the basic and continuing education of health workers who provide care in multicultural communities.

The fifth and final area of work is to identify and develop efficient mechanisms to coordinate, promote, disseminate, and exchange scientific and technical information. Annex A provides a list of the documents and publications prepared or in development at the close of 1996. A pamphlet about the Initiative and a video in English and Spanish are being disseminated throughout the Region. In 1995, a work group on research was held to begin a process of priority-setting and development of collaborative research projects addressing priority problems. Three indigenous researchers shared their experience and views and are part of a growing network of scientists who will provide guidance to deal with the numerous ethical issues which are inherent in the conduct of research, particularly in indigenous communities. This area of work corresponds to the last two responsibilities of PAHO in Resolution CD37.R5: overcoming the lack of information and promoting collaborative research.

From the beginning, PAHO has emphasized an intersectoral approach and the need to find partners who will work with it to carry out the Plan of Action or who have complementary plans. In May 1996, the Director of PAHO signed an agreement with the Indigenous Parliament of the Americas by which PAHO will work together with other international parliaments to develop and implement a plan to provide support to countries for the creation of a legislative agenda for national health policies, for legislation in the area of traditional healers and medicinal plants, and for legislators to work in other advocacy efforts for indigenous health.

3. LESSONS LEARNED

In implementing Resolution CD37.R5 and the Initiative, a number of important lessons have been learned which will provide criteria for reorienting future work.

Table 3 provides a summary of estimated expenditures and some projections for funding through 1998.

Table 3. Estimated Expenditures and Projections through 1998 (in US\$)

Year	Director	HSP-HSO	Region	Extrabudgetary
1993	60,000	100,000	5,000	See 1995
1994	110,000	100,000	55,000	46,000
1995	48,000	100,000	80,000	226,000
1996	17,000	120,000	71,000	255,000
1997		90,000	75,000	1,087,000
1998	50,000	90,000	100,000	2,000,000

Resource mobilization has taken longer than anticipated when the Action Plan was developed in 1995. Tracking the interprogrammatic effort continues to be a challenge, especially when a more general project includes a component or activities related to indigenous health. Negotiations with donors are ongoing as are attempts to find better ways of tracking efforts across programs. Also, in the future PAHO will initially focus on efforts which can be carried out with limited additional resources, encourage programs and countries to allocate small amounts of regular funds, and look for other less traditional donors.

Several countries have taken the position that they do not have indigenous peoples or that all citizens have access to health services; they argue that there is no need to focus on a particular ethnic group. Few countries routinely collect and analyze vital or service statistics by ethnic group, so it has been difficult to develop good baseline data for countries and to have an adequate assessment of health and living conditions of the indigenous peoples of the Region. Future efforts will be directed at promoting disaggregation of core data by ethnic group, with the goal of detecting and monitoring inequalities in health status and access to health services. Where this is not possible in the short term, substitute indicators will need to be found, such as core data for municipalities with 50% or more indigenous population as compared to national figures for the same indicator.

Not enough progress has been made in the systematic participation of indigenous individuals and their organizations. Very few countries have established technical government commissions with indigenous representatives, although a number have developed internal interprogrammatic task forces or commissions in the ministries of health. National indigenous institutes do not always have visible indigenous involvement, or, where indigenous-controlled, do not consider health as a high priority.

4. FUTURE PLANS

Based on the experience gained during 1993-1996, and in particular after two years of implementing the 1995-1998 Action Plan, four principal areas of work are proposed for 1997-1998:

1. strategic planning and management;
2. priority programs;
3. organization and delivery of health services in multicultural communities;
4. production and dissemination of scientific, technical, and public information.

Strategic planning and management continues to be a critical aspect of the Initiative in order to be consistent with the principles reflected in Resolution CD37.R5. During 1997-1998 the regional effort will be directed at promoting the Initiative in Phase 3 and Phase 4 countries. Because countries have had different responses to this promotion effort, it has been necessary to adapt the approach in countries to reflect this reality. For example, a few countries have responded to this promotion effort by naming national counterparts in ministries of health, having internal discussions to develop work plans, and holding consultation meetings with indigenous leaders and their organizations. Progress reports presented by countries through 1996 reflect a variety of efforts. However, few countries have developed baseline information on health and living conditions of indigenous peoples, established technical commissions with indigenous representation, or allocated PAHO country funds or funds from other sources to support activities specifically directed at improving the health and well-being of indigenous peoples.

Considering this varied response, expected evolution or staging of the Initiative in countries will in the future be: promotion, initiation, consolidation, evaluation.

Progress reports and minimum baseline information on indigenous peoples and their health and well-being will be the criteria for moving to the second stage, which will be the *initiation* of a process to develop responses to the situational analysis. A technical commission or other unit in government with indigenous representation and the allocation of PAHO country funds and funds from other sources are the criteria for moving to the next stage of *consolidation*. The inclusion of an indigenous health component or targeting specific ethnic groups with deficiencies in health status or health service access within national health plans, or the creation of a permanent unit in the Ministry of Health responsible for indigenous health with a majority indigenous staff, will be indicators for the final stage of *evaluation*.

A project, *Toward Health of Indigenous Peoples: Processes and Projects*, has been submitted to the Inter-American Development Bank and other donors for mobilizing supplemental funding to countries to support early efforts during initiation. This project requires the appointment of a technical commission and the allocation of country funds. It also includes support for training of indigenous leaders and for subregional networks which are indigenous-led.

Finally, a survey of national health policy planned in 1997 will provide additional information about current evolution in countries and permit comparisons among countries.

The second area of work is *priority programs* for indigenous health. PAHO will continue established priority programs, will consolidate efforts, and will develop new areas as other regional programs respond to promotion efforts and identify an interest in countries to develop concrete activities and projects with indigenous communities. A human resources database with indigenous experts identified for each priority program will be an important aspect. Where expertise does not currently exist, training for indigenous professionals will be encouraged. PAHO fellowships could be set aside by countries to prepare indigenous professionals in priority areas; this would be consistent with Resolution CD37.R5, which urges countries to strengthen the technical, administrative, and managerial capacity of national and local institutions responsible for the health of indigenous populations. Finally, collaborative research projects consistent with established priorities will be encouraged and resources mobilized. This approach has already yielded modest results, with an indigenous health component or project being included in a more general project in one or more countries. Table 4 provides a summary of the current and proposed priority programs as related to PAHO's strategic and programmatic orientations 1995-1998.

Table 4. Priority Programs Planned for 1997-1998 in Line with the Strategic and Programmatic Orientations

<i>Health and Development</i>
- Health and Living Conditions of Indigenous Peoples
- Indigenous Women, Health, and Development
- National Policy and Legislation on Indigenous Health
- Collaborative Research/Indigenous Health
<i>Development of Health Systems and Services</i>
- Community-Based Rehabilitation/Indigenous Models
- Traditional Health Systems/Indigenous Models
- Strategic Planning and Management/Indigenous Health Projects
- Medicinal Plants in Indigenous Health and Development
- Human Resources/Building Capacity in Indigenous Communities
- Toward Health of Indigenous Peoples of the Americas/Processes and Projects
<i>Health Promotion and Prevention</i>
- Mental Health and Psychiatric Services in Indigenous Communities
- Reproductive Health/Indigenous Communities
- Preventing Substance Abuse in Indigenous Communities
- Indigenous Adolescents
- Nutrition Intervention Projects in Indigenous Communities
<i>Environment</i>
- Basic Water and Sanitation/Improving Access in Indigenous Communities
- Migrant Workers Health
<i>Disease Control</i>
- AIDS and STDs
- Vaccine-Preventable Disease and Childhood Illness
- Vector-Borne Disease
- Tuberculosis
- Noncommunicable Disease in Indigenous Communities
- Diarrheal Disease including Cholera
<i>Other</i>
- NGOs for Indigenous Health Development
- Resource Mobilization
- Public Information/Health of Indigenous Peoples Initiative
- Scientific and Technical Information/Access and Production
- PAHO Staff Development

In *organization and delivery of health services in multicultural communities*, activities will include a focus on preparing health workers to provide culturally sensitive care in multicultural communities as well as in developing and field-testing guidelines and teaching materials to support this effort. Guidelines for the regulation, legitimization, or legalization of traditional healers will also be developed and disseminated in collaboration with the indigenous and other international parliaments. Since many indigenous peoples live in sparsely populated areas, innovative strategies to

provide access to basic public health and clinical services will be identified, systematized, documented, and disseminated through technical cooperation between countries' projects.

For *production and dissemination of scientific, technical, and public information*, efforts during 1997 and 1998 will be directed toward presenting information on health and living conditions of indigenous peoples in countries, in subregions, and in the Region as a whole. The available information will be used in the preparation of the new edition of *Health Conditions in the Americas*. Countries will be assisted in the preparation and publication of documents on indigenous health in their countries. Priority programs will produce and disseminate documents coming out of their work to include reports of work groups, evaluations of projects, and basic programmatic documents. PAHO is currently exploring possible sources of funding and technical support for a series of videos on indigenous culture and health development which will highlight the important contributions of indigenous cultures to health as well as showcase the variety of innovative approaches which are being developed as part of the Initiative.

Annex B provides details on these principal areas of work, some expected results, indicators, and how the area relates to Resolution CD37.R5.

Partnerships have become increasingly important in the delivery of technical cooperation in the Region. PAHO's partners for the Initiative include UN agencies, because of the focus on the Decade of the World's Indigenous Peoples. Also the Inter-American Declaration on Indigenous Rights, which specifically refers to the right to health, is being promulgated by the Organization of American States. These partnerships will continue to be an important aspect of the Initiative at the regional and country levels for the mobilization of technical and financial resources. Foundations, universities, and other institutions with expertise in indigenous health will also be sought out. Partnerships developed in the early stages will continue.

Much has been said and written about equity as a philosophical underpinning for PAHO's work in public health. However, as long as some communities have less service a greater burden of disease, and fewer opportunities than others, there will not be equity, and the goal of health for all will not be realized. We can—we must be—a collective voice, bringing these issues to the forefront for debate and resolution. With the indigenous communities, we will advocate for change, be persistent in our efforts and at the close of the Decade of the World's Indigenous Peoples, celebrate our shared success.

5. SUMMARY OF DISCUSSION OF THE SUBCOMMITTEE ON PLANNING AND PROGRAMMING, APRIL 1997

Delegates from countries reaffirmed their commitment expressed in Resolution CD37.R5, and to the principles formulated in the 1993 consultation workshop, commenting on work underway in countries to satisfy the mandate and to implement the Health of Indigenous Peoples Initiative. They described special projects in indigenous communities, programs for human resources development in multicultural communities, and special efforts to extend coverage for basic services to isolated areas where economic, geographic, and cultural barriers must be overcome.

Considering the limitations in financial resources, emphasis was placed on the need to establish priorities and to continue the strategy of building alliances.

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ANNEX A: SCIENTIFIC, TECHNICAL, AND PUBLIC INFORMATION

SCIENTIFIC, TECHNICAL AND PUBLIC INFORMATION

1. Background Document: Indigenous Peoples and Health (English/Spanish), HSP/HSO
2. Hemispheric Workshop '93 (English/Spanish/French), HSP/HSO
3. Health of the Indigenous Peoples (English/Spanish/) HSP/HSO, HSP/D #1
4. Video: Health of the Indigenous Peoples (English/Spanish) HSP/HSO
5. Health Conditions of the Americas, 1994 Selected references (English/Spanish) HSP/HSO
6. Grupos Étnicos en las Américas (Spanish) HSP/HSO
7. Informe Ejecutivo - Taller Subregional Mesoamericano Pueblos Indígenas y Salud (Spanish), HSP/HSO - HSP/D #3, #4
8. Actas del Taller de Guatemala Sobre la Ejecución de la Iniciativa (Spanish), HSP/HSO
9. Realización de los Talleres para Ejecutar la Iniciativa; Guías (Spanish), HSP/HSO
10. Toward a Comprehensive Approach to Health Guidelines for Research with Indigenous Peoples-Working Group on Research (English/Spanish), HSP/D #2
11. Pamphlet: Health of the Indigenous Peoples Initiative (English/Spanish) HSP/HSO
12. Grupo de Trabajo sobre Medicina Tradicional (Spanish), HSP/HSO
13. Fortalecimiento y Desarrollo de los Sistemas de Salud Tradicionales: Organización y Provisión de Servicios de Salud en Poblaciones Multiculturales (Spanish), HSP/D #6
14. Incorporating a Gender Perspective in the Work with Indigenous Peoples, HSP/HSO - HSO/D #5 (English/Spanish)
15. Informe del proyecto de CTP Bolivia-México sobre Terapeutas Tradicionales (Spanish), HSP/HSO
16. Recuperación de la Medicina Indígena, (Spanish) DEC
17. Condiciones de Salud de la Población Campesino-Indígena de la Sierra, (Spanish) DEC
18. Sistematización del Proyecto Pluricultural de Salud de Calderón, (Spanish) DEC
19. Indios, Derecho Consuetudinario y Salud, (Spanish) DEC
20. Informe del seminario sobre la Iniciativa de Colaboración ONG-Gobierno Fomentada por la OPS, (Spanish) DEC
21. Salud y Enfermedad en la Comunidad Maya K'iche' (Municipio de Totonicapán, Guatemala), (Spanish), DEC
22. Sistematización del Programa de Intervención de Salud en el Alto Napo, (Spanish) DEC
Lessons Learned in Working with Indigenous Women and Health: The Experience in Guatemala, MSD17/8 (English/Spanish), HDP/HDW
24. PAHO/WHO Plan of Action for Promoting the Initiative in the Region of the Americas 1995-1998 (English/Spanish) HSP/HSO
25. Plantas Medicinales para las 10 Enfermedades más Comunes en Guatemala. Manual del Instructor, DEC (Spanish)
Plantas Medicinales para las 10 Enfermedades más Comunes en Guatemala. Manual del Promotor, DEC (Spanish)
26. Manual Fitoterapéutico para el Uso del Centro de Salud Rural, DEC (Spanish)
27. Salud Mental y Poblaciones Indígenas en América Latina, HSP/HSO (Spanish)
28. Primer Encuentro de Salud y Pueblos Indígenas, OPS/CHI, HSP/D #7 (Spanish)
29. Progress Report -Health of Indigenous Peoples 1997, HSP/HSO, HSP/D #8 (English/Spanish/Portuguese/French)
30. Strategic Orientations for the Implementation of the Health of the Indigenous Peoples Initiative, HSP/HSO (Spanish/English)
31. Reunión de Trabajo sobre Políticas de Salud y Pueblos Indígenas, Quito, Ecuador HSP/HSO, (español)
32. Situación de Salud de los Pueblos Indígenas de Bolivia HSP/HSO (Spanish)
33. Situación de Salud de los Pueblos Indígenas de Chile, HSP/HSO (Spanish)

34. Situación de Salud de los Pueblos Indígenas de Ecuador, HSP/HSO (Spanish)
35. Situación de Salud de los Pueblos Indígenas de Guatemala, HSP/HSO (Spanish)
36. Situación de Salud de los Pueblos Indígenas de Honduras, HSP/HSO (Spanish)
37. Situación de Salud de los Pueblos Indígenas de México, HSP/HSO (Spanish)
38. Situación de Salud de los Pueblos Indígenas de Perú, HSP/HSO (Spanish)
39. Situación de Salud de los Pueblos Indígenas de Venezuela, HSP/HSO (Spanish)
40. Health Situation of Indigenous Peoples of Belize, Guyana and Suriname HSP/HSO (English)
41. Informe Grupo de Trabajo Programas y Servicios de Salud Mental en Comunidades Indígenas, Santa Cruz, Bolivia HSP/HSO (Spanish)

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June 1998

**ANNEX B: HEALTH OF THE INDIGENOUS PEOPLES INITIATIVE:
PLAN OF ACTION, 1997-1998**

Principal Components		
1.	<i>Strategic Planning and Management</i> <i>Profile:</i> 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 of the area of health and the environment for the benefit of specific indigenous populations (Resolution CD37.R5, 2.a). Strengthening of the operating capacity and the forging of alliances that take full advantage of the Region's financial and technical resources, since they constitute the critical factor in the implementation of Resolution CD37.R5 (2c, 3a, 3b).	<i>Resolution CD37.R5 (*)</i> (+) Member Governments PAHO 2a, 2b, 2c, 2d 3a, 3b, 3c, 3d, 3e
<i>Expected Results</i> <ul style="list-style-type: none"> - Promotion of the Initiative in Phase III and IV countries (ARG, BLZ, BRA, ELS, GUY, PAR, SUR and the remaining countries) - Strengthening of technical and financial cooperation alliances with national and international organizations - Establishment of Technical Commissions - Implementation of the project "Toward Health of Indigenous Peoples: Processes and Projects," at the national and subregional level - Training of indigenous leaders, professionals and focal points - Establishment with country funds of four fellowships per year for indigenous people - Survey of national policies on indigenous health 		
2.	<i>Priority Programs</i> <i>Profile:</i> Strengthening of 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 (Resolution CD37.R5, 2b). Promotion of 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 the countries (Resolution CD37.R5, 2e)	<i>Resolution CD37.R5</i> Member Governments PAHO 2c, 2e 3d, 3e
<i>Expected Results</i> <ul style="list-style-type: none"> - Consolidation of interprogrammatic efforts in the Regional Office and Country Offices - Expansion and implementation of interprogrammatic activities and projects with indigenous communities - Establishment of teams of indigenous experts and institutions for technical support - Establishment of coordination and technical cooperation mechanisms in the Organization with academic centers that have indigenous professionals and/or the endorsement of indigenous organizations - Expansion of the chapter about indigenous peoples in the publication: <i>Health Conditions in the Americas</i>, Vol. 1, in collaboration with Regional Programs 		

- * The numbers and letters in the right-hand column refer to the mandates for the Member Governments and for PAHO found in Resolution CD37.R5).
- + The promotion of collaborative research at the regional level and in selected countries on high-priority health issues and health care for indigenous peoples (Resolution CD37.R5, 3e) is an important aspect in each component of this Plan of Action.

Principal Components		
3. Organization and Delivery of Health Services in Multicultural Populations <i>Profile:</i> Within the framework of health sector reform, to promote the transformation of health systems and support the development of alternative models of care for the indigenous population, including traditional medicine (*) and research into quality and safety (Resolution CD37.R5, 2d). Identification of strategies that, within a legal, conceptual, and operational framework, permit the establishment and development of alternative models of care for multicultural populations that take into account the resources and potential of ancestral knowledge (Resolution CD37.R5, Preamble).	<i>Resolution CD37.R5</i>	
	Member Governments	PAHO
	2a, 2b, 2c, 2d	3a, 3d, 3e
Expected Results <ul style="list-style-type: none">- Development of programs and the preparation of training and instructional materials in health care for multicultural populations- Development of projects for multicountry technical cooperation to indigenous communities, and systematization and analysis of experiences in health service delivery in indigenous communities, within the framework of health sector reform- Identification of guidelines for the analysis and development of legislation and standards for the practice of traditional medicine- Implementation of activities in health and the environment geared toward specific indigenous populations- Establishment of a team of indigenous advisers in management, and management of alternative and/or complementary models for health service delivery		
4. Information Systems and Public Information <i>Profile :</i> Coordination of 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 (Resolution CD37.R5, 3c). Expansion of 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 regional level and country level (Resolution CD37.R5, 3d).	<i>Resolution CD37.R5</i>	
	Member Governments	PAHO
	2b, 2c	3c, 3d, 3e
Expected Results <ul style="list-style-type: none">- Mechanisms in place for the production and dissemination of public, scientific and technical information on the indigenous peoples of the Region- Development of audiovisual materials- Identification of strategies for the production, collection, and dissemination of information to indigenous communities- A process will be in place to strengthen national pride based on indigenous heritage		

* For example, medicinal plants: use, protection, marketing. The practice of traditional medicine: traditional therapists, intellectual property.

ANNEX C: EXCERPTS FROM SUMMARY RECORDS, 40TH DIRECTING COUNCIL

SIXTH MEETING (Wednesday, 24 September 1997

The session was called to order at 2:35 p.m.

ITEM 5.3: HEALTH OF INDIGENOUS PEOPLES

El Dr. WEINSTOK (Representante del Comité Ejecutivo) dice que, en la 120ª Reunión del Comité, la Dra. Sandra Land, del Programa de Organización y Gestión de Sistemas y Servicios de Salud, informó sobre los progresos realizados en la ejecución de la iniciativa de Salud de los Pueblos Indígenas, emprendida en 1993 de conformidad con la resolución CD37.R5.

La Dra. Land señaló cuatro aspectos clave: 1) Detectar y vigilar las diferencias étnicas en la situación sanitaria y la prestación de servicios, dado el carácter multilateral de la mayoría de los países de la Región; 2) formar capacidad indígena y forjar alianzas estratégicas; 3) promover y seguir, de forma interprogramática, los esfuerzos de nivel nacional; y 4) valorar los sistemas de salud y los curanderos tradicionales, a la vez que los servicios de salud básicos más adecuados desde el punto de vista cultural.

Los Estados Miembros habían logrado avances en el fortalecimiento de la capacidad de las instituciones nacionales y locales encargadas de la salud indígena y en la ejecución de acciones intersectoriales en la esfera de la salud y el ambiente, en colaboración con las organizaciones indígenas. En el área de los sistemas y servicios de salud, se habían emprendido esfuerzos para desarrollar modelos alternativos de atención que incluyeran la medicina tradicional. La OPS había promovido la participación de los indígenas y sus comunidades, movilizandorecursos adicionales y coordinando un esfuerzo regional interprogramático.

Sobre la base de la experiencia adquirida en 1993-1996, se propusieron para 1997-1998 cuatro áreas de trabajo principales: planificación estratégica y gestión para apoyar el progreso continuo en la ejecución de la iniciativa; desarrollo y fortalecimiento de los programas prioritarios para la salud indígena; organización y prestación de servicios de salud en comunidades multiculturales; y producción y difusión de información científica, técnica y pública sobre salud y condiciones de vida de los pueblos indígenas.

Cuando el Subcomité de Planificación y Programación abordó el tema en abril de 1997, subrayó que una de las dificultades principales para dar a las comunidades indígenas acceso a los servicios de salud era su aislamiento geográfico. Los grupos indígenas padecían además un aislamiento político, social y cultural, y era necesario mejorar su participación política y su capacidad de negociación y de liderazgo. El Subcomité consideró que las orientaciones y los planes para el trabajo futuro eran acertados, aunque quizá la lista de actividades de cooperación técnica propuestas resultara demasiado ambiciosa, dadas las limitaciones de personal y presupuesto.

El Comité Ejecutivo se hizo eco de esa preocupación en el mes de junio, e insistió en la necesidad de concebir modelos de asistencia sanitaria adaptados a las necesidades y características

culturales de las comunidades indígenas, así como en la de incluir a los propios pueblos indígenas en la elaboración de programas de salud y la prestación de servicios. El Comité alentó a la OPS a prestar cooperación técnica para perfeccionar el liderazgo y la aptitud de los líderes indígenas para defender los intereses de sus pueblos. También se consideró esencial la cooperación entre los países, especialmente porque el territorio de las comunidades indígenas rebasaba a veces los límites de un país.

El Comité señaló asimismo que la Región de las Américas había estado en la vanguardia de los esfuerzos realizados en la OMS para mejorar la salud indígena y que, aunque había que superar aún grandes retos, la Organización podía enorgullecerse de los progresos logrados. El Comité aprobó la resolución CE120.R10 sobre el tema.

Mr. COCHRANE (Canada) commended PAHO for its continued dedication and commitment to mobilizing energy and resources to improve the health of indigenous populations throughout the Americas. Canada shared the Organization's concerns regarding the inequities in health status of indigenous peoples. Many of Canada's indigenous people experienced the same health problems as other indigenous groups throughout world, including high infant mortality and high rates of communicable and respiratory disease. However, they also had a rising incidence of chronic diseases such as diabetes. Some progress had been made in narrowing the gap in health status between the country's indigenous and non-indigenous populations, but much remained to be done. With regard to the document before the Council (Document CD40/14) and the action plan and areas of work proposed for 1997-1998, his Delegation considered capacity-building within aboriginal communities—both in terms of human resource development and management—to be of utmost importance. Ultimately, governments were limited in what they could do to reduce the health status inequities of indigenous peoples. Their role was to create the conditions that would enable the aboriginal peoples themselves to make decisions and take action to address their own health concerns. Canada's strategy was therefore aimed at ensuring that First Nations and Inuit peoples had autonomy and control over their health programs and resources through community-based indigenous health programs.

A fundamental element in encouraging aboriginal control over health, health care, and well-being was recognition of the importance of traditional knowledge and medicine. Aboriginal people themselves must be trained as health care professionals, providers, and managers, because they were best able to integrate their culture, language, and practices into health care programs. Enhancement of community-based health care delivery would also help to alleviate the access problems associated with the geographic isolation of many indigenous communities.

Canada planned to establish an aboriginal health institute comprising a network of centers of innovation in aboriginal health. Although the network was still in the development stage, centers devoted to aboriginal training, diabetes, information management, and other topics were expected to be included. Another promising initiative in Canada was the development of an aboriginal health information system, aimed at improving information collection and management to ensure that decisions on indigenous health were evidence-based. The system was to be extended to virtually all indigenous communities and would eventually be integrated into the Canadian health *infrastructure*.

The Canadian government was committed to working in partnership with indigenous peoples to improve their health, and was supporting their efforts to take charge of their own institutions and assert their own identity and rights with regard to health and the environment, as outlined in the proposed resolution submitted to the Directing Council. Canada would welcome the opportunity to share its experience and to facilitate the sharing of experiences of its aboriginal communities. His Delegation encouraged all governments to work together in partnership with their own indigenous populations and other stakeholders to determine culturally appropriate solutions to the challenges of eliminating health inequities for the Region's indigenous peoples.

Hon. Doreen PAUL (Dominica) said that her Delegation wished to acknowledge PAHO's efforts to draw attention to the issue of indigenous health. In Dominica, the Carib indigenous group made up 3.5% of the total population. The country did not have a separate health service for Caribs, but its primary health care approach had enabled it to offer the same health care to the indigenous population as to other Dominicans. Within the Carib territory there were three health centers with resident nurse-midwives, assisted by community health aids. A district medical officer conducted outpatient clinics at the centers. Serious cases were referred to health care facilities outside the territory.

The Government of Dominica had encouraged international and nongovernmental organizations to deal directly with the indigenous people, which had facilitated the implementation of local projects proposed by the Carib Council and had assisted the Carib people in taking responsibility and improving their managerial skills. The Government had also provided scholarships for training indigenous people and, in collaboration with NGOs, had mounted vigorous health promotion campaigns in areas such as family life education, skills training, assistance for the establishment of income-generating activities, backyard gardening to improve nutrition, and family planning. Dominica would continue its efforts to address the problems and needs of the Caribs, particularly teenage pregnancy, family violence and child abuse, unemployment, and inadequate housing conditions and education. However, it would welcome support from PAHO and other organizations, especially to help fight the spread of tuberculosis and substance abuse among the Carib people, in particular youth. The Government of Dominica wished to thank PAHO for its past support and looked forward to working with the Organization on the priority programs planned for 1997-1998 in the framework of the Health of Indigenous Peoples Initiative.

El Dr. PICO (Argentina) expresa su satisfacción por la inclusión de este tema en el programa, y felicita al Comité Ejecutivo por el trabajo realizado. La Argentina, en el marco de sus políticas nacionales de salud aprobadas por el poder ejecutivo para todo el territorio nacional y del intenso proceso de transformación y reforma que está realizando, tiene un programa especial de salud de los pueblos indígenas. Ese programa le permite avanzar con arreglo a tres criterios: la no discriminación, la no desigualdad y —fundamentalmente— la integración.

Un dato que indica la importancia que se da a ese programa en el presupuesto de 1998 es que se duplica el número de agentes sanitarios, a fin de poder llegar a las distintas comunidades étnicas del país, poniéndolas directamente en contacto con los médicos y el personal de atención primaria de salud, e integrándolas en el sistema escalonado de servicios. Por otra parte, las acciones se articulan y coordinan con las de otros ministerios, como el de trabajo y el de educación, a fin de lograr la

integración definitiva en la sociedad. Por todo ello, la Delegación de la Argentina se suma al esfuerzo que está realizando la OPS y pide al Director que haga avanzar la iniciativa a fin de lograr la ambiciosa meta de salud para todos, integrando plenamente a los hermanos aborígenes de los distintos países.

El PRESIDENTE dice que el debate sobre el tema se va a suspender temporalmente, a fin de ocuparse del tema 5.2, que era el inicialmente previsto para esta sesión.

EIGHTH MEETING (Thursday, 25 September 1997

The session was called to order at 2:30 p.m.

AGENDA OF SUMMIT IN SANTIAGO

ITEM 5.3: HEALTH OF INDIGENOUS PEOPLES (*continued*)

El Dr. PIERUZZI (Venezuela) dice que el documento que se ha presentado al Consejo aborda el tema de manera integral y por eso lo apoya con vehemencia. Venezuela está intentando que los seis países del Tratado de Cooperación Amazónica lleven adelante un programa de trabajo con la participación comunitaria de los indígenas, que son parte considerable de la población amazónica. Al hacerlo, se tendrán en cuenta los criterios de la OPS en relación con esta esfera. Además, en el Sistema Andino de Integración, de la Comunidad Andina, también se han tenido en cuenta esos mismos criterios como parte del programa de fronteras saludables. Por otra parte, el orador destaca la importancia de respetar las tradiciones culturales de los indígenas y su lucha permanente por la tenencia de la tierra y por salir del abandono y de la exclusión en que se les ha sumido injustamente. Hay que rescatar las aportaciones de los indígenas a la cultura latinoamericana en general.

Ms. VALDEZ (United States of America) said that the subject of indigenous peoples had special significance for her country, which had a total of 550 sovereign tribe nations. The Indian Health Service was one of the largest agencies in the Department of Health and Human Services and was the only agency that had a completely integrated health service system.

The data in Document CD40/14 made even clearer the challenges confronting all the countries in addressing the inequities and health problems faced by indigenous peoples.

One of the Organization's recent achievements was its agreement with the Indigenous Parliament of the Americas. Strong legislative agendas would be critical for developing sustainable national health policies, and she believed that PAHO could be a valuable partner with the countries in developing public health policy guidelines that would impact indigenous groups. PAHO could also contribute to the development of leadership, as well as negotiation and advocacy skills among indigenous leaders; provide baseline data on the current health status of indigenous peoples; and help to initiate discussions at various levels to effect changes in health policies, legislation, and attitudes.

Referring to the Executive Committee's comment on the ambitiousness of the technical cooperation proposed by PAHO, especially in light of the resources available, she suggested that

PAHO would be most effective if it would prioritize its activities and focus on smaller successes so that progress could really be ensured.

Hon. Gail TEIXEIRA (Guyana) said that a number of issues not covered in Document CD40/14 needed emphasis. Among them was the need for information on the guidelines being employed for research involving Amerindian people, particularly the studies of their health status and anthropological investigations being carried out by universities of the North about which the rest of the Region had no knowledge.

Another issue requiring emphasis was the need to integrate indigenous peoples into society at large. They should not be marginalized and treated as if they were enclaves of exotica. Health services, in particular, had to be part of the overall development of the communities in which indigenous peoples lived, and that development should include opportunities for education, jobs, training, and, above all, participation in decision-making. In Guyana's Parliament, 16% of the members were of indigenous origin, representing land areas that occupied two-thirds of the national territory. Indigenous people constituted 6% of the country's total population.

The speaker also emphasized the importance of creating educational opportunities for indigenous peoples, especially in the health services. She cited Guyana's program of community health workers, which had trained 250 foot soldiers of the health services—99% of them Amerindian—to work in the riverine interior. Those jobs were stepping-stones that enabled them to get into nursing, medical assistant programs, and other allied health fields that were generally closed to indigenous people because of the scarcity of secondary education in their areas. It was also important to point out that job training for Amerindians helped to reduce poverty in their communities.

Another issue that had not been stressed was the need for the right balance between environmental protection and sustainable development in the exploitation of the countries' interiors, as well as the importance of protecting indigenous peoples from exploitation by companies involved in mining and timber.

El Dr. SAMAYOA (Honduras) informa que en su país, con la intención de dar cobertura con equidad, se ha decidido considerar el concepto de etnias, en el que se incluyen grupos indígenas, como los misquitos, con quienes se tiene una deuda social e histórica de varios siglos. Sin embargo, existen otros grupos étnicos como los garífunas, cuya llegada al país es más reciente, que también padecen la falta de equidad en materia de atención de salud. Por consiguiente, es preciso adoptar un punto de vista integral para que el concepto de etnia no lleve a olvidar a otros grupos aparte de los indígenas.

El Dr. WEINSTOK (Costa Rica) pone de relieve que en su país los servicios de salud se prestan a toda la población, incluidos los indígenas. Los indígenas costarricenses son ante todo costarricenses y no hay razón para considerarlos distintos ni darles un trato diferente. Es posible, desde luego, que por razones de ubicación geográfica a veces tengan dificultades de acceso a los servicios, pero el derecho a la asistencia sanitaria es el mismo que el de todos sus conciudadanos. Para resolver el problema de la dificultad de acceso se ha procurado fortalecer los servicios de

atención primaria. Es verdad que ha habido grupos postergados, por ejemplo, el de las mujeres y el de los indígenas, a los que en un momento dado es preciso prestar más atención; pero, en definitiva, cuando se trata de prestar servicios a la población hay que considerar a ésta como un todo, sin establecer diferencias. En Costa Rica no hay un problema indígena; el problema estriba en prestar servicios a toda la población porque todos son costarricenses.

El Dr. MARTÍNEZ (Nicaragua) destaca la importancia del tema, fundamentalmente por la posibilidad que ofrece de realizar acciones que permitan reducir las desigualdades e inequidades que sufren las comunidades indígenas, particularmente cuando tienen como asiento natural regiones geográficas aisladas. Agradece de manera especial el apoyo que la OPS ha brindado al Ministerio de Salud de Nicaragua para mejorar las condiciones de vida y la salud de las comunidades de misquitos. Aprovecha la oportunidad para invitar a los hermanos hondureños a desplegar esfuerzos conjuntos en favor del desarrollo integral y la salud de los misquitos a ambos lados de la frontera.

Dr. LAND (PAHO) emphasized the importance of capacity-building within the indigenous communities themselves and called specifically for the preparation of indigenous health professionals, including scholarships to help young health workers move to the professional level. She said that PAHO had trained two indigenous interns from Bolivia and would be receiving five more in the near future.

She noted that there had been support for many of the priority programmatic areas and also that some new areas had been mentioned, which would be discussed and incorporated into the next plan of work. Collective efforts would be necessary, and PAHO would facilitate technical cooperation between countries and forge new partnerships or strengthen existing ones in order to better detect, monitor, and reverse inequities in health and find ways to overcome the cultural, geographic, and economic barriers that stand in the way of extending care to the vulnerable groups of the Region, in particular the indigenous peoples.

The DIRECTOR referred to a basic philosophical difference in how indigenous persons were treated. In some countries there was the idea that indigenous persons and practices should be fully incorporated into the general scheme of things, whereas in other countries indigenous peoples themselves wished to remain separate, maintaining their own cultures and practices and dealing with their health situations themselves. PAHO had respect for both philosophies and would be working with the countries to draw experience from both.

Second, he raised the issue of formal contact between PAHO and indigenous peoples. The Organization had received requests to sign agreements with indigenous peoples as separate nations, but was unable to comply because PAHO could only have formal relationships with governments.

Another point he wished to emphasize was that, whereas PAHO could not really provide health services as such, it could help countries to monitor the situation among indigenous peoples so that inequities would become apparent and the possibility of measuring the value of interventions would therefore be greater.

It was not easy to mobilize extrabudgetary resources for the area under discussion, but PAHO would endeavor to do so and continue to proceed in the way that the Members had clearly agreed was appropriate.

The RAPPORTEUR presented the resolution contained in Document CD40/14.

THE XL 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:

1. 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 World's Indigenous Peoples, and to approve the activities proposed in Document CD40/14.
2. 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.
3. 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.
4. To request the Director to continue his efforts to implement the Health of Indigenous Peoples Initiative.

Decision: The proposed resolution was adopted.