Social Assessment

GUYANA HIV/AIDS PREVENTION AND CONTROL PROJECT

Indigenous People's Development Plan (IPDP)

1. Introduction

1.1. The HIV/AIDS Prevention and Control Project. With grant funding from the World Bank to support the *National Strategic Plan for HIV/AIDS, 2002-2006*, the Government of Guyana will implement a 5 year multi-sector HIV/AIDS Prevention and Control Project whose objective is: to slow the spread of HIV infection and mitigate the socio-economic impact of HIV/AIDS. The project will cover interventions across the whole country but special effort will be made to reach specific population groups that are particularly vulnerable to Sexually Transmitted Infections (STIs)/HIV/AIDS and their associated consequences. These include commercial sex workers, women, youth, orphans, PLWHA, and remote populations including indigenous groups.

The lack of resources and weak institutional base has resulted in Guyana's limited response to the epidemic. The coverage of most interventions, including IEC, VCT, management of STIs and programs targeting youth, has been limited to Georgetown and a few other urban centers mainly along the coast. Interior regions depend on laboratory services in Georgetown to process blood samples. The infrastructure required to closely screen for and monitor HIV/AIDS is extremely weak with an estimated 60% under-reporting of HIV/AIDS cases. The lack of epidemiological data on the epidemic, and services (including staff, drugs and equipment) to address emerging problems, is particularly acute for hinterland regions. A great deal of work will therefore be required to lay the groundwork for an expanded response to the epidemic, particularly in previously under-served areas.

1.2 Purpose of the Indigenous Peoples Development Plan (IPDP). Although the HIV/AIDS project will be implemented nationwide, one of the World Bank's social safeguard policies[1], Operational Directive 4.20 (OD 4.20) on Indigenous Peoples (IP), applies because the majority population in a number of the regions to be covered are IP. The objective of the directive "is to ensure that indigenous peoples do not suffer adverse effects during the development process, particularly from Bank-financed projects, and that they receive culturally compatible social and economic benefits"[2]. Guyana's IP fit the following five distinguishing characteristics used to identify minority nationality communities that may warrant special attention in project planning. Although there may be regional variations in the degree to which these characteristics are present, the indigenous peoples of Guyana can be said to: (a) have a close attachment to ancestral territories and natural resources in their region; (b) identify themselves and are identified by others as members of distinctive cultural groups; (c) have languages different from the national language; (d) still have customary social and political institutions; and (e) rely primarily on subsistence modes of production.

[1] There are 10 safeguard policies covering Environmental Assessment, Natural Habitats, Forestry, Pest Management, Cultural Property, Indigenous Peoples, Involuntary Resettlement, Safety of Dams, Projects in International Waters, and Projects in Disputed Areas

[2] The World Bank Operational Manual – Operational Directive OD 4.20 September 1991

The Government, through a participatory process with IP communities and various other stakeholders, will support and or implement a number of activities to address specific HIV/AIDS related issues in the indigenous population. The expected project benefits for IP include:

a) Enhanced knowledge about STIs and HIV/AIDS and methods of prevention, care and treatment
b) Access to resources for community-based priority STI/HIV/AIDS activities
c) Empowerment through a participatory process particularly for the Village Councils and local organizations to plan, implement and evaluate local initiatives.
d) Strengthened health care system capacity to conduct tests (laboratories services), refer and treat persons infected with HIV or suffering from AIDS
e) Strengthened Primary Health Care services including the referral system

The three project components will address IP needs as follows:

1.3 Legal Framework. *The 1976 Amerindian Act* is the main law in Guyana that deals with Amerindians. The 1976 Act is based on laws that date back to the early 20TH century British colonial rule. It is widely recognized that the law is outdated. In 1993, a Parliamentary Committee was set up to initiate the revision of the Act. This process has suffered several delays but in 2002, the consultation process with communities was initiated. The process of consultation is now complete and final recommendations being summarized for final review by communities before presentation to Cabinet. The Government hopes to adopt the new Act in 2004. In addition, Amerindians are supposed to enjoy the basic rights of all Guyanese guaranteed under the Constitution[3] including the right to health care.

1.4. Guyana's Indigenous Peoples. Guyana has an estimated indigenous population (IP) of 8% of the total population of 800,000. The Amerindians, as the IP are known, belong to 9 distinct groups[4] or tribes who make up the majority population in the interior region of the country bordering Surinam, Brazil and Venezuela. Most Amerindians live in about 131 highly scattered communities in Regions 1, 7, 8 and 9, many of them sparsely populated. Region 1 has the highest concentration of Amerindians in the country followed by Region 9. Over the years, as the hinterland has been opened up for development, and with the establishment of logging/lumber exploitation/industries and mining, there has been an increase in the number of indigenous people, particularly men, migrating to other areas, especially urban centers, for work.

The indigenous people of Guyana are disproportionately disadvantaged socially, and economically. Amerindians have some of the lowest health indicators in Guyana. Social development indicators for health and education reveal significantly higher levels of disease, as well as mortality, and higher illiteracy rates when compared to other non-indigenous groups in the country. Few Amerindians have access to potable water and, since the early 1980s, traditional sources of potable water (creeks and rivers) are under threat of pollution resulting from the rapid growth of extractive industries in the interior.

Poverty is rife with close to 80% of the Amerindian population in the country falling below the poverty line with Amerindian women especially affected by poverty[5] . Women are paid lower wages and salaries than men, and cannot easily access credit facilities[6]. The majority (over 70%)

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[3] Guyana: Constitution, 1980 with 1996 reforms.
www.georgetown.edu/pdba/Constitutions/Guyana/guyana96.html
[4] Carib, Warao, Arawak, Akawaio, Patamona, Makushi, Arekuna, Wapishana and Wai Wai
[5] Guyana PRSC Program Document – Annex VII
[6] Health Sector Analysis Guyana. PAHO & MOH

of Amerindians are engaged in subsistence activities such as agriculture, hunting and forestry. The high incidence of poverty in the hinterland is largely the result of geographic isolation (the economic reforms of the 1990s did not benefit many Amerindians[7]), and limited economic activity[8].

Health: The overall poor state of health is reflected in low life expectancy, with less than 5% of Amerindians living to be 55 years or older compared to the average life expectancy for Guyana of around 64.8 years (61.5 for males and 68.2 for females). Malaria is endemic and the leading health problem in the interior. It is also noted that at one time, almost a third of the tuberculosis cases were found in the Amerindian population. In the hinterland area, regions 1, 4, 7, 8 and 9 have the highest rates of tuberculosis. With the growing HIV/AIDS epidemic however, there has been a growing shift of cases to the coastal population, particularly young men aged 25-34. Worm infestation is also endemic in most interior regions. Other poverty related diseases afflicting Amerindian communities include diarrheal diseases and acute respiratory infections[9]. The Amerindian communities are also significantly affected by substance abuse, dental carries and snake bites. Although the country's immunization program is considered successful, the hinterland regions (I, 7, 8 and 9) have the lowest coverage as a result of inadequate management, transport, communication and difficulties maintaining the cold chain. Amerindian women are at higher risk of poor maternal health as fewer births (43%) in the hinterland are attended by trained health care workers. Various health initiatives have been started mainly with UNICEF/DfID support such as IMCI, training in immunization and primary health care issues, and a community project in malaria management (Region 9).

Education: Until recently, there were no mechanisms to ensure a coordinated approach to education programs for Amerindian communities. Hinterland schools lack trained teachers and suffer from scarce supplies. Not surprisingly, school attendance rates tend to be low. Less than 13% of poor households in the interior regions have received secondary education and, only 1% of Amerindians have received post-secondary education. With the creation of a Ministry for Amerindian Affairs, a scholarship program has been established for the secondary and post-secondary education of hinterland students.

2. Health Services in the Interior Regions

As in other regions of Guyana, populations in the hinterland are served by a network of primary health care facilities, which provide free health services. Guyana's health care system has five tiers: Level 1 is the health posts, Level 2 the health centers, Level 3 are District Hospitals followed by Regional Hospitals at Level 4 and the national referral Hospital at Level 5. For many dispersed settlements in the hinterland, the main service providers are CHW (Table 1) who staff the health posts located in the community. A higher cadre of staff, the Medex (physician's assistant) is located at health centers which are the next link in the referral chain. Access to private health care providers is limited as most private practitioners are located in the Georgetown area and other urban locations along the coast.

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[7] Poverty Reduction Support Credit 2002

[8] Guyana Poverty Reduction Strategy Paper 2002

[9] Health in the Americas, 2002 Edition, Volume II, pp.323-335

Table 1: Government Health Facilities in the Interior

Region (Population)	Type and number of Health facility				
	Regional Hospital	District Hospital	Health Center	Health Post	TOTAL
1 (18,294)*		3	4	31	38
7 (14,682)*		1	3	15	19
8 (6,137)**		1	4	16	21
9 (14,947)*	1	2	3	52	58

Sources: PHC Services Model – Modeling PHC Services Development. Draft 1: 8 March 2002.; National Health Plan 2003-2007, MOH 2003; *Guyana Poverty Reduction Strategy Paper 2002; **Prepared by Institute for Health Sector Development, London for MOH Guyana; ◦Report on Region 9's Poverty reduction Strategy Consultations (2001) prepared by the Regional Democratic Council # 9 in collaboration with the Amerindian Touchaus' Council of Region #9

All the health centers and health posts are expected to provide maternal and child health (MCH) services. Outreach services and home visits are also conducted particularly where vaccination targets have to be reached, and to deliver post natal care. However, services are not always accessible or provided as planned due to a number of factors including:

Geographical and financial barriers: The interior region is an area difficult to access because of the dense forest, mountains and vast savannah. The country is intersected by many rivers, creeks and other water ways, and some communities can only be reached by boat transportation. For the health sector, the terrain presents special challenges to delivering health care services to highly dispersed communities, making service delivery not only more difficult but costly. The problems of service delivery and access are further compounded by poor or limited road networks, and limited boat and vehicular transportation. Many communities can only be reached on foot. Despite health care being free of charge, financial factors may also influence access especially with respect to transportation and cost of accommodation and food for patients and family caregivers from communities farthest away from health facilities.

Shortage of staff: There is a lack of qualified health personnel at all levels of the system (doctors, nurses, mid-wives, and community health workers), due to a number of reasons including out-migration of health professionals, unwillingness on the part of staff to be posted in the hinterland because of low wages and the difficult working conditions.

Inadequate means of communication: Due to the isolated location of many health centers and health posts, communications with regional headquarters for support is critical especially when emergencies arise (e.g. pregnancy related complications, vehicular accidents, snake bites). Many facilities lack radio sets and telephones, or the equipment is in need of repair.

3. HIV/AIDS and Indigenous People

Current data on HIV/AIDS indicates that prevalence rates among the indigenous populations are still low. However, the Government recognizes that under reporting of HIV/AIDS cases is a

severe problem (MOH estimates 60% underreporting of cases[10]), the result of which is that the true magnitude and determinants of the epidemic are largely unknown[11] and it can be assumed to be even worse where indigenous people are concerned. Surveillance will therefore be a primary focus of the GOG HIV/AIDS Strategic Plan and this includes the collection of pertinent information on all vulnerable groups including indigenous peoples. Already, the data collection form used for requesting HIV tests and reporting HIV cases, AIDS cases and AIDS deaths, has been revised to include information on race and ethnicity[12].

3.1 Factors that increase vulnerability of Indigenous People to HIV/AIDS. Although HIV/AIDS prevalence is still low in the interior regions, the potential exists for the problem to escalate if actions are not taken now to prevent the spread of the disease in the indigenous populations. Factors that increase the vulnerability of indigenous people in the hinterland to HIV include: poverty (the underlying issue) and lack of employment opportunities leading to out-migration for jobs in urban areas or mines – risky behaviors abound in such environments, and returning workers may carry the HIV virus back to their home area; high rates of STIs in some communities, inadequate or lack of information and knowledge about HIV/AIDS and how to prevent it, prostitution among the women, alcoholism, lack of access to services, and high teenage pregnancy rates. Furthermore, the proximity of IP communities to neighboring countries (Brazil, Venezuela, Suriname) lures men and youth across borders in search of jobs, and yet others to access health care services including HIV testing and treatment. As the National Strategic Plan for HIV/AIDS 2002-2006 acknowledges "With the opening up of Guyana's hinterland for development, the proposed Guyana/Brazil road, and the subsequent increase in the transient population, a further increase in the prevalence of HIV/AIDS in the interior regions is anticipated"[13].

3.2 Current HIV/AIDS activities in Indigenous Areas. There have been a number of HIV/AIDS related activities, mainly focusing on IEC, in the hinterland regions initiated by various donors, NGOs, local organizations and the Ministry of Health. These efforts however have suffered from a lack of coordination and their impact in terms of coverage remains unknown. The Ministry of Amerindian Affairs is in the process of establishing a national data-base of activities affecting Amerindians and through the HIV/AIDS Project will ensure improved coordination with all actors engaged in HIV/AIDS in hinterland regions.

4. Development of the Guyana Indigenous Peoples' Development Plan (IPDP)

4.1 Methodology. The preparation of the IPDP was led by the Ministry of Health and the Ministry of Amerindian Affairs, and coordinated by the Consultant with support from the World Bank Representative in Guyana. The IPDP was developed through a consultative process with a number of stakeholders including IP communities that stand to benefit from the HIV/AIDS Prevention and Control Project.

4.1.1 Literature review. A review of existing documents was conducted to obtain information on Guyana's Indigenous peoples, their general welfare, the regions they inhabit, and the

[10] In 1997 sensitivity of the reporting system was approximately 65% - Status Report on HIV/AIDS in Guyana 1987-2001, prepared by Dr. Navindra Persaud, MoH

[11] Status Report on HIV/AIDS in Guyana 1987-2001, prepared by Dr. Navindra Persaud, MoH

[12] MOH, Guyana. Unified Form for Requesting HIV Tests and Reporting HIV Cases, AIDS Cases and AIDS Deaths

[13] National Strategic Plan for HIV/AIDS 2002-2006, p.2

current status of HIV/AIDS in Indigenous populations, health conditions in the interior, and the type and number of health facilities and staff in regions 1, 7, 8 and 9. This study also benefited greatly from the PRSP documents. A draft outline of the IPDP was prepared by the Consultant based on the review and was used to structure discussions with MoH and other stakeholders.

4.1.2 Discussions and Interviews.
(i) Ministry of Health. To prepare the ground for consultations with communities in the regions as well as identify key informants in Georgetown and in the regions, discussions were held with MOH officials focusing on the purpose of the IPDP, the process to be undertaken and, most importantly, the need for Government commitment to and ownership of the process and outcome. The MoH advised on the regions to visit and communities to consult Two MOH persons were also identified to join the core team for the field visits.

(ii) Ministry of Amerindian Affairs. The *Minister for Amerindian Affairs, the Honorable Carolyn Rodrigues*, was briefed about the mission and plans to visit the hinterland. The Minister briefly outlined the challenges to delivering services in the interior regions, and highlighted the need to address two critical issues: transport (especially cost) and incentives for health personnel. The Minister also confirmed her support to the IPDP and as a commitment to the process agreed to lead and facilitate consultations in region 1.

(iii) Other Stakeholders. Meetings were also held with representatives of two of the agencies whose cooperation and collaboration will be central to implementing the IPDP, the Amerindian Research Unit, University of the Artistes in Direct Support, a group of Guyanese artists formed in 1992 who use the performing arts to educate communities about HIV/AIDS, particularly youth. The group, through its Theatre Caravan, has worked with IP communities both in urban areas and in the interior.

4.1.3 Consultations with Indigenous Peoples. The core element of the methodology involved extensive consultations with IP communities and local organizations in the hinterland, IP residing in Georgetown as well as representatives of IP organizations based in Georgetown. Visits were also made to 4 health facilities: a regional hospital, a health center and 2 health posts.

4.1.3.1 Objectives of the community consultations were to:

(a) inform IP about the government's health development plan, the HIV/AIDS strategic plan, and the World Bank supported project and its objectives
(b) inform IP about the government's plan to involve IP in developing interventions that address issues of priority to IP, including HIV/AIDS
(c) discuss HIV/AIDS, determine the amount of information about the disease, and activities available to IP communities. Question were prepared to guide the team in the discussions with the various stakeholders is attached.
(d) engage IP community members in identifying HIV/AIDS risk factors in the communities, as well as solutions to prevent and control the epidemic and
(e) discuss other issues they consider most pressing or priority (including how they could be resolved).

4.1.3.2 Consultation Team Members

The core consultation team comprised 4 members who visited Regions 1 and 9. The team members were as follows:

(i) Team for Region 1: Hon. Carolyn Rodrigues, Minister for Amerindian Affairs; Mr. Wilton Benn, Senior Medex, MoH; Ms. Lucia Hanmer, Country Representative, World Bank[14]; Ms. Jean Rutabanzibwa-Ngaiza, Consultant, World Bank.

(ii) Team for Region 9 : Dr. Bheri Ramsaran, Director, Regional Health Services, MoH; Mr. Wilton Benn, Senior Medex, MOH; Ms. Lucia Hanmer, Country Representative, World Bank; Ms. Jean Rutabanzibwa-Ngaiza, Consultant, World Bank.

In the regions the core team was met by regional officials who not only facilitated the visits (informed the communities, arranged the meetings, welcomed the team) but actively participated in the discussions with community members. The team observed a real desire on the part of community leaders to be part of the HIV/AIDS prevention effort and indeed lead some of the initiatives in their communities.

Four villages in Region 1 and, in Region 9, three villages were visited and meetings held with the following stakeholders in the border town of Lethem: 4 members of Regional Leadership Team[15], a separate meeting with Youth Leaders belonging to a local church; 3 members of a youth group and around 15 members of two women's groups from St Ignatius township/village, and a Member of Parliament actively involved with the youth and women's organizations.

4.1.3.3 Georgetown Consultations.

Amerindian Hostel. The team met with approximately 65 IP, representing 23 villages in Regions 1, 7, 8, 9, and 10 currently residing temporarily at the Amerindian Hostel[16]. Only 15 people (23%) had heard of HIV/AIDS mainly through word of mouth, schools (many years ago) and pamphlets distributed by truckers passing through the villages. Some of the points raised by participants included:

- AIDS information on pamphlets not easy to understand
- Use local trainers to sensitize community about the disease
- Use varied media including Videos/VCR, TV and work through existing village structures, also bring in other actors in the community such as shopkeepers
- VCT nearer the communities would be supported – now many have to travel to Georgetown for medical tests.

The Cyril Potter College of Education. The 40 final year students were from a number of regions including hinterland regions 1, 7, 8 and 9. The group was better informed about HIV/AIDS than the hostel dwellers, and had access to more sources of information. The students worked in small groups to identify HIV/AIDS risk factors in their regions and suggest solutions. Their work has been incorporated into Table 2. Some of the risk and vulnerability factors included:

- society's tolerance of men having multiple partners
- poverty and high rates of unemployment that spawned prostitution and substance abuse
- lack of knowledge about HIV/AIDS in poor areas

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[14] Team composition for Region 1: Senior Medex (MOH); Minister for Amerindian Affairs; Consultant, and Country Representative, World Bank.

[15] Regional Chairman, Regional Vice Chairman, School Welfare Officer, Regional Health Officer

[16] Residents include patients who have been referred to Georgetown for treatment (sometimes accompanied by a relative), women at risk of complicated deliveries

Job creation and skills-training, training local persons as HIV/AIDS trainers; providing parents with information so they could discuss the disease with their children, working with churches and making condoms accessible were some of the solutions suggested by the group.

The Rural Women's Network, an umbrella organization for 60 local women's groups in the 10 regions. In existence for 4 years, the Network has been assisting groups to build capacity through training in *inter alia* marketing and bookkeeping. Some of the affiliate members work on health issues including AIDS. The Network appears to have enough capacity to take on the role of facilitating agent for local groups that want to initiate HIV/AIDS related activities under the HIV/AIDS Prevention and Control Project. They agreed to assist the MOH prepare a questionnaire to assess the capacity of local NGOs.

Finally, a meeting was held with representatives of two Amerindian NGOs: The Amerindian Action Movement of Guyana (TAAMOG), and the Guyanese Organization of Indigenous Peoples (GOIP) to inform them of the on-going work in health including preparation of the HIV/AIDS project and the necessity of preparing an IPDP. Both organizations were involved in the preparation of the GOG HIV/AIDS Strategy 2002-2006. They stressed the need to build training institutions in the regions to avoid uprooting students from their environment, to consider what role the church could play especially in working with youth and, to translate HIV/AIDS materials into local languages.

4.2 Results of the community consultations. The following issues were identified at nearly all the meetings:

Information on HIV/AIDS. In all the communities visited, the majority of community members reported having heard of HIV/AIDS although few had a clear understanding of what the disease was. The most common sources of information were health workers, the radio and for youth, teachers in schools. Generally, exposure to information on HIV/AIDS through outreach activities had often times been a 'one off' activity in which they participated, some as far back as two or even three years ago. The lack of information was not only confined to community members. A few health workers (CHW) appeared ill-informed and inadequately equipped to discuss HIV/AIDS. Some community members even expressed their lack of confidence in health workers' ability to transmit the necessary information on HIV/AIDS to the community. Two other groups mentioned often as needing support in the way of training, and empowering with HIV/AIDS information were teachers and parents.

Where information pamphlets and posters had been made available, it was felt that such materials needed to be not just culturally appropriate, but in the languages of the local communities, and also include other communication media such as drama/shows, community radio and videos. A number of community members also indicated the importance of seeing 'the face of AIDS' if HIV/AIDS information is to have some impact on behavior. The involvement of PLWHA in this effort may therefore be critical to the success of IEC.

With respect to priority needs for prevention of HIV transmission, in all the communities there was concern about the lack of information on how many had already been infected or were sick. Although support for testing centers was expressed, it was evident that the exposure of those infected could be used by some community members to 'settle scores' and or stigmatize individuals. Where such views were expressed, team members from MOH used the occasion to emphasize the voluntary nature of HIV tests, the need to avoid blame, and the importance of community support for those facing misfortune.

Knowledge about condoms as a means of preventing HIV appears to be universal but responses regarding their use seem to indicate limited or non-use. One problem appears to be the limited outlets, with most condoms supplied by health workers. Men especially were reported to be reluctant to collect condoms from the health facilities.

Concern was also expressed about the unsatisfactory state of the health system which could not respond adequately to the existing problems because of various problems including lack transportation for health workers (fuel shortage), a district hospital had no doctor and inadequate drugs, there was limited choice of family planning methods, village health posts lacked furniture, and ill-equipped laboratories.

Gender issues were evident in the responses given by community members regarding risks and vulnerability to HIV/AIDS. The risks were slightly different for women and young girls especially. The lack of education or economic activities made girls fall prey to truckers and other men passing through the villages. Also, the presence of mining and other camps in the region induced young girls to begin consorting with miners, and soldiers. There were also gender issues with regard to promotion of condoms, and PMTCT. Some women mentioned the absence of men in all these efforts and wondered why the male role was hardly or never mentioned in the transmission of the virus when discussing PMTCT. Emanating from the discussion was a recommendation to utilize institutions that have all or majority male membership to integrate men into the HIV/AIDS campaigns such as using Village Captains to introduce HIV/AIDS topic at sub-district meetings and raising the topic at public meetings of the RDC and Chambers of Commerce.

Young people in the communities are concerned about the lack of opportunities for gainful employment, and recognize that staying idle encourages risky behaviors thus putting youth at risk of HIV. This concern was also echoed by community members and leaders (Captains and Touchous) who called for support for local initiatives and activities that involve particularly out-of-school youth. Information on HIV/AIDS for both in and out-of-school youth was said to be inadequate. Alcohol consumption and use of drugs (marijuana in particular) is reported to be on the increase in the villages. The priority needs identified by youth include:

- AIDS awareness in communities
- Training of peer educators on an ongoing basis
- Training for counselors
- Information on healthy lifestyles, including posters and leaflets in local languages on the negative impact of drugs and alcohol
- Information on STIs
- Outlets for condoms – apparently condoms were not easily accessible. The main source is the health worker. Few shops in the rural areas sell condoms and none are found in bars/places of entertainment

The Church as an institution in many of the communities appears to exert quite a lot of influence, especially over behavior. In one community for example alcohol consumption was kept under control through the efforts of a councilor (an active church member) to educate the community about the dangers of consuming too much alcohol. The councilor also speaks with business owners to limit the amount of alcohol sold, especially during holidays. A number of speakers noted during discussion that the teaching of values was critically needed as a means of curbing negative behaviors. Generally, community members felt that Churches were the best placed institutions to influence behaviors, starting with youth. A number of young people were members of youth clubs run by local churches. A few of these clubs were engaged in disseminating HIV/AIDS prevention messages, emphasizing mainly abstinence and fidelity. However, the

churches are willing to work with local authorities in sensitizing communities about HIV/AIDS and are also in need of support including materials and training. In one village, the Village Captain who is also the pastor at his church indicated his willingness to receive training in HIV/AIDS counseling.

The women's groups were formed mainly as income generating ventures and they vary in size and capacity. Activities include sewing, gardening, cashew nut processing and revolving fund. Members acknowledged the lack of information and awareness of HIV/AIDS in the communities. They were concerned about youth, especially those already out of school who may not have access to information on AIDS, and are willing to initiate HIV/AIDS activities but require support.

Factors that place individuals and communities at risk. Numerous factors were mentioned at meetings suggesting a general awareness of risks. There was a tendency to perceive risks as emanating from outside the community, for example, with some community members blaming 'the road' (Georgetown –Lethem road) for bringing bad influences into the community including HIV/AIDS. Others suggested 'outsiders' be tested for HIV before being allowed into the communities (e.g. non- local teachers, health workers, business owners). These perceptions are a result of inadequate information, fear created by the knowledge that HIV/AIDS is deadly and perhaps an inadequate understanding of the risk factors fueling the spread of HIV.

In Table 2 are some of the risk factors, internal and external, identified by Amerindian communities as increasing their vulnerability to HIV/AIDS, along with proposed responses to prevent or control the epidemic.

Table 2: Risk and Vulnerability Factors* Identified by IP and Proposed Interventions

Factors increasing risk and vulnerability of indigenous communities to HIV/AIDS	**Proposed Interventions**
1. Poverty and associated factors (illiteracy, unemployment, inadequate knowledge about health, prevention)	- Employment creation in the hinterland - Establish skills training centers & institutions
2. - Exploitation of resources in indigenous areas (mining, lumber) - Roads and/or railroads - Tourists/ visitors - Development projects (power, water) & other businesses bringing outside workers (increase potential for communicable diseases) - Social disruption caused by especially mining (women & youth suffer disproportionately e.g. sexual exploitation, young girls consorting with miners, violence, crime)	- Companies should establish HIV/AIDS and STI programs/services that include community sensitization regarding HIV/AIDS - Require that certain percentage of jobs set-aside for local labor -
3. Migration of youth to regions with better opportunities or to neighboring countries (education cut short as youth gravitate towards economic betterment) - travel to and from work camps	- Community development projects to include youth -HIV/AIDS VCT and STI testing and treatment services for workers
4. Lack of or Inadequate access to health and other social services	- Strengthen health services by ensuring that adequate numbers of trained personnel are available and accessible -train indigenous health agents -mobile and extension clinics to increase access - Ensure adequate supplies of drugs and equipment at health facilities -For HIV'AIDS – establish testing centers close to the communities
5. Substance abuse (alcohol, drugs)	- Enforce age limit for sale of alcohol (i.e. no sale to minors) -IEC regarding link between alcohol & substance abuse and risky behaviors - Educate both young and old about the dangers of alcohol abuse Involve parent teacher association
6. Early sexual activity (50% of children have sex before by age 13)[17] Teenage pregnancies[18]	- Education for girls - Health and Family Life Education in schools -Adolescent Reproductive Health Services
7. Cultural beliefs and practices: - men expected/allowed to have multiple sex partners - parental reluctance to speak to children about sensitive issues such as sex (they also lack information & knowledge about HIV/AIDS) -belief that evil spirits responsible for illnesses such as STIs & AIDS -inadequate concern about personal health therefore resort to self-treatment	- Behavior change interventions (BCC) including education for both males and females that emphasizes the importance - Educate and provide information for parents to enable them to comfortably speak with their children about subjects considered taboo such as sex -IEC regarding diseases and treatment -research on extent of influence of cultural beliefs & practices on health seeking behavior

*Issues and proposed solutions identified during community consultations in Regions 1 & 9; and consultation sessions with hinterland student teachers at Cyril Potter College of Education, and the Amerindian Hostel both in Georgetown.
**Table adapted from: *Indigenous Peoples Development Plan: Brazil AIDS III Project IPP-37*

[17] 1998 Adolescent Health Survey quoted in Health Sector Analysis Guyana
[18] In 1999, 24% of births were to girls aged 15-19 years. See Chapter on Guyana in Health in the Americas 2002

Although a number of HIV/AIDS initiatives have been undertaken by the MoH, donor agencies and NGOs for a few years now, the findings of the consultations would suggest the following: (a) there has been inadequate community sensitization in hinterland communities regarding HIV/AIDS, (b) many of the health workers, and teachers who are expected to disseminate HIV/AIDS information lack the capacity and knowledge to adequately do so, (c) parents and other family members need to be well informed so they can reinforce the messages taught in school, (d) there is a dearth of culturally and language appropriate communications materials, resulting in low levels of understanding of the disease.

However, opportunities exist at local level that could be utilized to scale up the response to HIV/AIDS: (i) local leaders and grass-roots organizations for women and youth for example, have initiated activities that respond to community needs including dissemination of information, albeit limited, on HIV/AIDS (ii) community institutions such as Churches are engaged in educating communities about HIV/AIDS, and are willing to work with local authorities to expand the efforts, (iii) local leaders appear willing to take the lead and are requesting support in a number of areas including training, setting up of testing centers and information dissemination.

5. Government of Guyana HIV/AIDS Plan for Indigenous Communities

There is a unique opportunity that will enable an effective response to some of the concerns identified through the consultation. The Ministry of Amerindian Affairs is one of the Ministries that is included among selected ministries to implement the Guyana HIV/AIDS Prevention and Control Project. The Ministry will undertake specific activities for indigenous peoples; serve as a catalyst for ensuring that civil society organizations are encouraged to undertake activities for indigenous peoples through the demand driven component; and, liaise with other Ministries especially the Ministry of Health and Education to ensure that the activities that they undertake focus on the special needs of indigenous peoples. The Minister of Amerindian Affairs will also be a member of the Government's Presidential Commission on HIV/AIDS which will ensure that at policy level, the needs of the IP's are taken into account.

The IPDP will be implemented through the different components supported by the Project. Ministry of Amerindian Affairs will work closely with the other ministries involved in the Project to ensure that activities targeting IP are implemented. A number of actors including NGOs and other civil society organizations will be key players in implementing the IPDP.

More specifically, the IPDP under the HIV/AIDS Prevention and Control Project will focus on the following activities:

5.1 Information, Education and Communication (IEC)/Behavior Change Communication(BCC).

The key IEC/BCC activities in IP communities in the interior will involve NGOs, CBOs, FBOs and the private sector. While the component is demand-driven with the civil society groups obtaining funding through proposals. The Government will also solicit some of the organizations to focus on priorities. Among the priority activities to be solicited will be:

a) Preparation and dissemination of IEC/BCC materials.
i) Translation of key messages and documents into local languages in collaboration with the Amerindian Research Unit, local leaders and others experienced in preparing culturally appropriate visual aids and other materials.

ii) Preparation and dissemination of materials on HIV/AIDS and STIs in collaboration with Amerindian Research Unit, University of Guyana. Socio-cultural research will be undertaken (under Component 1) on *inter alia* the contextual issues that determine or influence sexual behaviors. Results will be utilized in designing IEC materials and community sub-projects.
iii) Preparation of age-appropriate materials for youth, in and out-of-school.

b) Promotion Campaigns. Intensive community sensitization will be undertaken on HIV/AIDS, stigma reduction, and behavior change interventions/communication (**BCC**) to target those at higher risk such as youth, and particularly young girls. Information will be disseminated on voluntary testing, availability of VCT and STI services including GOG position on protecting the rights of individuals (legal rights) and protection from harassment and harm. This process will actively involve all relevant stakeholders including traditional and local leaders, and civil society organizations.

c) Capacity building workshops. Persons and groups expected to disseminate HIV/AIDS information to communities will receive training through workshops and other fora. Priority will be given to training persons from within and or residing in the communities as trainers and peer educators. Such persons include: Teachers, Community Health Workers, Village Captains and Councilors, and community development workers. Local groups such as women's and youth groups will also receive training and regular support to access relevant, up-to-date information on HIV/AIDS.

d) Community mobilization, proposal preparation. The Ministry of Amerindian Affairs will conduct training for community groups and NGOs on proposal preparation for funding from the demand-driven part of the project.

e) Condom promotion and provision
Currently, the target group has been primarily women who are provided with male condoms by health workers (and expected to 'use' them). This, however, has not empowered women to protect themselves since they have not been provided with methods they can control such as spermicides and female condoms. NGOs working on social marketing of condoms as well as free distribution will be encouraged to work with indigenous communities. Support for this activity would also come from MOH as part of its plan. An amount of US$ 600,000 has been provided in the project for procurement and distribution of condoms. Some of the condoms will be earmarked for distribution to IP communities.

5.2 Voluntary Counseling and Testing (VCT) Supported under Component 3.

The expansion of VCT services under the Project will include IP areas both at region and sub-district levels. This will include training of trainers and counselors from within the community. Communities indicated the need for counselors to be persons of integrity, respected by community members and able to keep all information they are given confidential. Such persons include church leaders, teachers and community elders.

a) VCT centers will be constructed or refurbished and provided with the necessary furniture, equipment, and test kits and training provided to health workers including community health workers.
b) IEC materials will be designed in collaboration with the Amerindian Research Unit and other partners such as CBOs and NGOs.
c) Training activities will be designed and implemented for teachers, church leaders and other leaders in the community in Guidance and Counseling skills (for teachers, impart HFLE

methodology and incorporate HIV/AIDS topics into school curriculum). The importance of and need to assure confidentiality will be emphasized.

5.3 Treatment , Care and Support for PLWHA and their families (Support under Components 1, 2 and 3)

Key activities:
a) Treatment of opportunistic infections – training health care workers including CHW in use of protocols to diagnose and treat infections, ensuring adequate supplies of drugs including antibiotics. Given that ARI is a major problem, particularly among young children, the strengthening of drug supply systems will also benefit curative services under primary health care.
b) Training health care workers in care of PLWHA, and home care providers – guidelines for home care-givers will be developed (too include nutrition for PLWHA)
c) Provision of basic home care kits – a standard kit, and guidelines will be developed.
d) Support for CBO, FBO and NGOs to provide care and support for PLWHA
e) Provide ARVs – these would be made available through the MCH program as part of the PMTCT program.
f) Increase TB screening[19] and improving DOTs coverage and completion rates by training and involving local organizations and leaders in the distribution and monitoring of compliance.
g) Roving Medical Hinterland Teams: To adequately ensure that IP communities have enhanced access to services mentioned above, outreach teams will be established in Regions 1, 7, 8 and 9 to deliver services to the remote communities. This aligns with the PRSP[20] policy action of providing one medical outreach team in each region. Where these teams already exist, they will be strengthened and their role expanded as necessary. The teams will conduct scheduled visits (frequency as yet to be decided) covering entire sub-districts. The 'Roving Medical Hinterland Teams' would undertake outreach activities with particular emphasis on the most isolated communities in regions 1, 7, 8 and 9. The team would include activities focusing on HIV/AIDS related issues. As yet to be elaborated are the team composition, their tasks and responsibilities.

5.4 Initiate Private Sector Activities and Enhance Collaboration (Support under Component 2)

a) The Ministry of Amerindian Affairs will undertake a survey of private companies operating in the interior regions to ascertain type of health care provided for employees
b) Work with each company prepare HIV/AIDS plan detailing priority activities. Each company, by year two, provide VCT, STI testing and treatment and or referral for employees

c) Cross-Border Issues (Support under Component 1). To address cross-border issues related to health,
d) More health officers will be recruited in the hinterland
e) Inter-ministerial collaboration between MoH, Ministry of Amerindian Affairs, Ministry of Foreign Affairs and border authorities will be strengthened to facilitate information sharing on the number of persons crossing the border for health care, including those seeking HIV tests and people undergoing treatment for AIDS. Already efforts are underway to provide Portuguese language training for border (immigration) officials.

5.6 Ministry of Health. In addition, to activities highlighted above, there are specific activities under the Health sector component which are cross-cutting but important for IP.

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[19] Regions lack facilities to do this - see Report on Region 9's Poverty reduction Strategy Consultations (2001) prepared by the Regional Democratic Council # 9 in collaboration with the Amerindian Touchaus' Council of Region #9
[20] see Guyana Poverty Reduction Strategy Paper, Appendix 5.

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a) A high priority activity under the project is the development of a comprehensive IEC/BC communications strategy. It will help to identify appropriate ways of reaching different target population groups including IP with appropriate IEC/BCC interventions. An amount of US$ 50,000 has been programmed for a consultancy on developing the IEC/BCC strategy.

b) Surveillance and Research will be critical to implementing the IPDP. As recognized in Guyana, data on the extent of the epidemic and coverage of services is inadequate. An amount of US$ 30,000 has been included for Knowledge, attitudes, practices and behavior surveys. These will include IP areas.

5.7 Ministry of Education

The activities highlighted below are key priority activities under the Ministry of Eduction's response to HIV/AIDS. IP schools and teachers will be included in the programming of these activities. The roll-out of the program will be undertaken in annual work plans that are currently being developed.

a) Integrate HIV/AIDS into school curriculum – under HFLE
b) Skills training for teachers involved in HFLE
c) Integrate HIV/AIDS into teacher training curricula
d) Establish/revive school health clubs

6. Monitoring and Evaluation. There are six ongoing or planned date collection activities supported by a number of agencies including USAID, Centers for Disease Control (CDC), CIDA and Caribbean Epidemiology Center (CAREC). It is expected that they will provide baseline information for monitoring the epidemic including among IP. Monitoring of activities under the IPDP will be covered under the M & E framework for the project. Evaluation studies will be designed to take into account the key focus areas of the IPDP, including prevalence in IP communities, increased knowledge of HIV/AIDS, access to STI/HIV/AIDS services, behavior change, and participation of civil society and the private sector. IP have been included in the mid-term and final impact evaluations.

7. Time line and Costing. While some of the activities have been costed, especially those to be managed by the Ministry of Health, a number of others for line ministries will be detailed on an annual basis, while those of NGOs and other civil society organizations will be prepared through a proposal based demand-driven process.