Indigenous Peoples Development Plan: Brazil AIDS III Project

I - AIDS and Indigenous Peoples

Indigenous Peoples: Brazil has an estimated indigenous population of some 350,000 Indians. This population is distributed over almost every state in Brazil, comprising 587 officially recognized Indian reservations (*terras*) and some 215 different societies and cultures speaking 180 languages. Almost 55% are located in the Northern Region, with the State of Amazonas accounting for 26% of Brazil's total indigenous population; 17% are in the Center-West region, 18% in the Northeast, 2% in the Southeast, and 8% in the South.

However, it should be noted that this information does not include those Indians now living in the metropolitan areas of Brazil's major cities. This population is estimated at approximately 50,000 Indians, with the greatest concentrations in the cities of Manaus and Manacapuru (Amazonas), Campo Grande and Dourados (Mato Grosso do Sul), and Águas Belas (Pernambuco), together with lesser concentrations in such metropolitan regions as São Paulo, Porto Alegre (Rio Grande do Sul), Brasília, Chapecó (Santa Catarina), and Londrina (Paraná). Migration to and settlement in major urban areas varies enormously, from temporary movements for health care, work and education, to relocations rooted in the individual mores and practices of certain indigenous cultures resulting in the presence of sizable Indian population groups in urban areas, which Stephen Baines has described as representing "large temporary villages for paid work." It is also important to draw attention to the urban areas of Brazilian cities bordering on other countries, such as the regions of Tabatinga/Benjamim Constant (Peru and Colombia); Rio Branco (Bolivia); Boa Vista (the Guianas); Guajará-Mirim (Bolivia); Corumbá (Bolivia); and Foz do Iguaçu (Paraguay).

The areas with the greatest concentrations of Indians that are most vulnerable to HIV/AIDS are listed below, by tribal groups:

STATE		TRIBE	CASES DE AIDS
Amazonas:			
URBAN AREA	Manacapuru	Apurinã	
	Manaus – Conjunto Santos Dumont	Sateré-Maué	X
BORDER		Ticuna	X
	Benjamim Constant		
	Tabatinga		
Roraima:			
URBAN AREA	Boa Vista/Bairro Pintolândia and Raiar do Sol	Guianese Indians	X
Acre:			
URBAN AREA	Rio Branco	Various groups	
Mato Grosso do Sul:			
URBAN AREA	Dourados	Guarani	X
	Campo Grande	Terena	X
BORDER	Corumbá	Terena	

Pernambuco: URBAN AREA	Águas Belas	Fulni-ô	X
São Paulo: URBAN AREA	Jaraguá Favela Real Parque Favela Paraisópolis	Guarani Pankararu Pankararu	X
Rio Grande do Sul URBAN AREA			

Cases of AIDS and STDs: The **CN-DST/AIDS** (STD/AIDS National Coordinating Office – *Coordenação Nacional de DST/AIDS*) received reports of 52 cases of AIDS among the indigenous population over the period 1986-2001. The first case of AIDS among indigenous peoples was reported by **FUNAI** (National Foundation for the Indian – *Fundação Nacional do Índio*) and the **MS** (Ministry of Health – *Ministério da Saúde*) in 1988, in the State of Santa Catarina, in the southern region of Brazil.[1] Since then, additional cases were identified in other regions. The epidemic affected mainly Indians who had regular contacts with the surrounding society and who traveled relatively frequently to the cities or were in contact with populations living in border cities.[2] Currently the indigenous population that has been most severely affected by the epidemic is that in Mato Grosso do Sul. The principal characteristic of this region is that it has the largest number of Indians living in urban areas. Thus, the distribution of cases of AIDS and of STDs within the indigenous population cannot be viewed in a uniform manner, as from an epidemiological point of view there are significant differences in vulnerability, since many of these Indians are in regular contact with the population living in villages.

Regional distribution of AIDS cases: The regional distribution of AIDS cases among the indigenous population confirms the general tendency discussed above, namely that the number of cases of AIDS is greatest in the Center-West and Northern regions and that it is to be found in urban areas and in small and mid-sized municipalities. This tendency shows how important it is to gain a better understanding of the interaction networks that develop from contact with the surrounding society and associated risk factors. The table below shows the number of cases and a percentage breakdown by region. The spatial distribution of the indigenous population in the South and Southeast regions, where the first cases were reported, is characterized by the presence of villages located very close to urban areas and with a highly mobile population, resulting in more frequent interethnic interactions. The Center-West region has today, the largest number of cases, and has shown a higher growth in cases than other regions. This contrasts with other parts of the country, since most of the cases being reported in the Center-West involve Indians living in urban areas, with women being those most affected. The variables that come into play here include poverty, prostitution among Indian women, and alcoholism. The first of the graphics appended to this report shows the spatial distribution of AIDS cases by **DSEI** (Special Indigenous Health District – *Distritos Sanitários Especiais Indígenas*).

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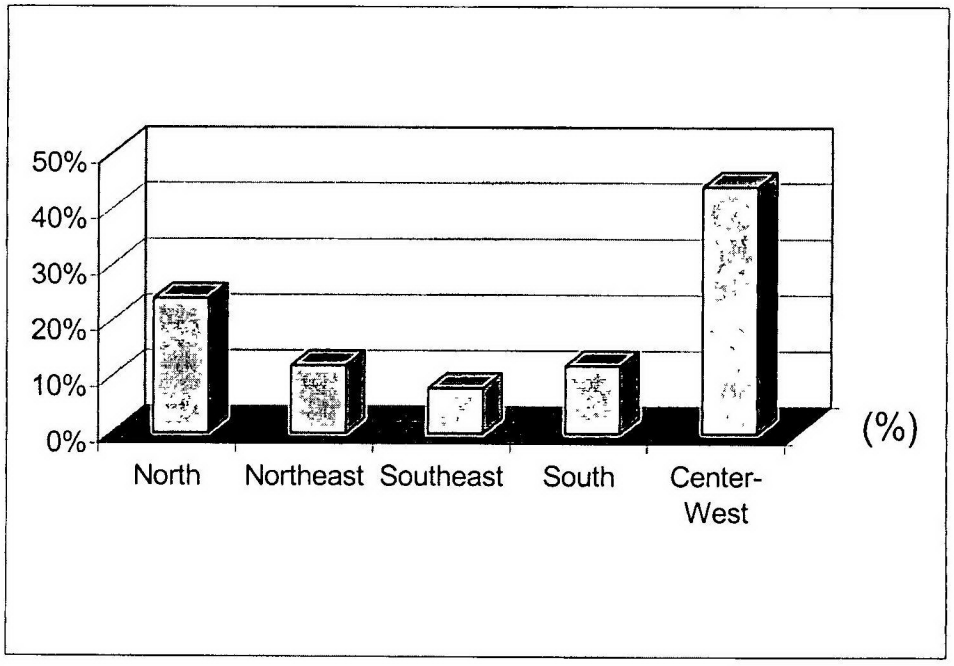
[1] Flávio Wiik, *Contato, epidemia e corpo como agentes de transformação: um estudo sobre a AIDS entre os Índios Xokléng de Santa Catarina* Cadernos de Saúde Pública, 17 (2): 397-406, Rio de Janeiro, 2001.
[2] Leonardi, V.; " *Fronteiras Amazônicas do Brasil Saúde e História Social*" Ed. Marco Zero & Paralelo 15. Brasília, 2000.



Regional Distribution of AIDS Cases among the Indigenous Population – 2001

Distribution of AIDS cases by sex and age group:

In Table 1 we show the percentage distribution of AIDS cases, by age group and sex. The age group most affected are individuals between the ages of 20 and 34, representing 68.0% of total cases, or 65.2% for males and 79.2% for females. It should be noted that women are becoming the most vulnerable group and consequently those who bear the greatest impact of the socio-cultural changes affecting their group. In general, the increased frequency of contacts with individuals outside the group, particularly for male Indians who travel regularly to cities and towns near their villages and/or who move back and forth between the cities and the villages, together with increased prostitution among Indian women, alcohol consumption and the sexual mores of the group, are all factors responsible for the spread of the epidemic among village Indians.

As regards the reporting of AIDS cases in urban areas, it should be noted that many cases involving the indigenous population are likely to be underreported. A recent study by the Centro de Referencia Terapéutico in São Paulo, based on a review of patient records, showed a much larger number of AIDS cases among Indians than had been expected, with 22 patients identifying themselves as Indians. **SINAN** (the Reportable Diseases Information System – *Sistema de Informações sobre Agravos Notificáveis*) only started including the race variable in 1996.

Percentage Distribution of AIDS Cases among the Indigenous Population - 2001

AGE GROUP (YEARS)	MALE	FEMALE	TOTAL
15 to 19	01 (4.3%)	01 (4.2%)	02 (4.0%)
20 to 24	02 (8.7%)	04 (16.6%)	06 (12.0%)
25 to 29	06 (26.1%)	11 (46.0%)	17 (34.0%)
30 to 34	07 (30.4%)	04 (16.6%)	11 (22.0%)
35 to 39	04 (17.4%)	01 (4.2%)	05 (10.0%)
40 to 44	03 (13.0%)	01 (4.2%)	04 (8.0%)
45 to 49	-	-	-
50 to 64		02 (8.2%)	02 (4.0%)
Age unknown	No data	No data	03 (6.0%)
TOTAL	23 (100%)	24 (100%)	50 (100%)

Source: CN-DST/AIDS - Ministério da Saúde

In sum, the major tendencies and characteristics of the AIDS epidemic among the indigenous population are as follows:

(a) The epidemic is growing and is expanding among Indians living in urban areas who maintain frequent contacts with their villages;
(b) The younger population is the most vulnerable, with individuals between the ages of 20 and 34 representing 68.0% of total cases, or 65.2% for males and 79.2% for females;
(c) As a category, young women are the most severely affected group with a sex ratio of 1/1, and their vulnerability is linked to various factors, such as early sexual initiation, differing sexual mores across tribal groups, cross-lactation, school attendance, and the socioeconomic impact of major projects.

But these factors can only be understood on the basis of existing risk and vulnerability differentials within the population.[3] The social networks that people form are rather complex, and require an effort in terms of characterizing and identifying them in their anthropological and political dimensions, and determining how they operate in the spread of disease. Thus each ethnic group needs to be placed within the context of its own particular situation and related to the broader dynamics of interethnic contacts, such as:

(a) interethnic contacts resulting from the entry into native areas of *garimpeiros* (unlicensed miners), woodcutters, farmers and ranchers, and development projects, e.g. construction of hydroelectric power plants and building of roads);
(b) interethnic contacts involving indigenous peoples in border areas;
(c) seasonal mobility and migration of Indians to urban areas in search of work, education and health care;

[3] Ministério da Saúde: *Povos Indígenas e a prevenção às DST, HIV e AIDS Manual de diretrizes técnicas* Brasília, DF, 2000.

(d) kinship structure and sexual customs among some tribal groups that may increase risks and promote vulnerability, such as cross-nursing, scarification rituals, polygamy, and early sexual initiation;
(e) breakdown in traditional structures of community authority;
(f) conflict between the concepts of traditional medicine and the Western concept of the health/disease process, as a result of which many health professionals find themselves unprepared to cope with these situations and reject traditional beliefs, making preventive measures difficult.

INDICATORS FOR RISK AND VULNERABILITY DIFFERENCES FOR INDIGENOUS PEOPLES

External Factors Increasing Vulnerability of Indigenous Communities	Internal Factors within Indigenous Communities Increasing Risk and Vulnerability	Institutional Responses
1. Exploitation of forest resources	1. Level of purchasing power and schooling	1. Situation regarding regularization of title to indigenous lands
2. Authorized and unauthorized mining operations on indigenous lands	2. Level of political power and capacity to mobilize support	2. Existence of Indians employed by public institutions who travel frequently
3. Roads and/or railroads	3. Balance in kinship relations and gender issues	3. Presence of community development projects
4. Leasing of indigenous land	4. Level of knowledge about health situation and how diseases are transmitted	4. Existence of special indigenous health districts and access to health services
5. Power sector projects	5. Permanent residents from outside the group and mobility of higher-status individuals within the group	5. HR policy for the training of indigenous health agents
6. Squatter invasions	6. Inter-group and inter-ethnic relations	6. STD/AIDS programs established in the DSEIs
7. Rural centers and land settlement projects	7. Indigenous presence in urban centers	
8. Presence of regular travelers	8. Sexual mores within the group	
9. Presence of indigenist agencies		

Cases of STDs

In Figure 2 (see Annexes) the coefficient of incidence shows just how serious the STD problem is in some districts. In general, in nearly all of the DSEIs, cases of STDs are higher than among the population in general, with incidence rates usually above double digits. But particularly deserving of attention are situations where incidence rates reflect general epidemic conditions, as is the case in Manaus, Altamira, Alto Juruá, Alta Purus, Maranhão, Ceará, Pernambuco, Cuiabá,

Xingu, Araguaia, Amapá and northern Pará. The data do not indicate what type of infection is most frequent, as the reporting system adopted by the DSEIs does not classify cases by etiology. Nevertheless, it is important to stress the need to prioritize STD prevention and treatment measures, as a correlation with HIV infection is more likely in situations like these where high STD rates are prevalent. The spatial distribution of STDs also coincides with what the data reveal about the distribution of AIDS cases. Once again, young people and women are the segments of the population who are most affected.

II –The Government's Response

Legal framework governing indigenous health: Responsibility for indigenous health currently resides with the Ministry of Health, which regulates and implements health actions – both prevention and treatment – through a care model based on 34 Special Indigenous Health Districts (*Distritos Sanitários Especiais Indígenas*) or DSEIs. Each DSEI has centralized (*pólo*) care units which conduct health operations within the villages. Most of this network is operated by civil society organizations (NGOs) under agreements with the National Health Foundation (*Fundação Nacional de Saúde* – FUNASA) for basic care activities. For more complex operations, the system operates through agreements and incentives with the **SUS** (*Sistema Unificada de Saúde* – Unified Health System). STD/AIDS operations are conducted in the DSEIs, and the CN-DST/AIDS provides technical assistance in program implementation, training of health care professionals, and standardization of activities in conformity with indigenous health care policy. Social oversight is exercised through the District Councils and by the Inter-Institutional Committee for Indigenous Health (*Comissão Interistitucional de Saúde Indígena* – CISI) and by the National Health Council (*Conselho Nacional de Saúde* – CNS). The AIDS Committees (*Commissões*) of the states and municipalities play a complementary role in this social oversight, as does the Office of the Public Prosecutor (*Ministério Público*) in the case of human rights issues and invasion of Indian lands.

With respect to AIDS/STDs prevention, treatment and care responsibility for coverage is shared between FUNASA and the National AIDS/STD Coordination as established in the National Conference on Indigenous Health of 2000. The AIDS/STD program is responsible for the development of technical norms and guidelines, educational materials, monitoring and evaluation, training of local administrators at state and municipal levels and the provision of technical assistance to DSEIs. Actual basic care and prevention services delivered in indigenous communities are the responsibility of the DSEI/FUNASA, and of the States and Municipalities, who can contract NGOs. Thus, under AIDS III, there are three types of financing mechanisms for indigenous health (AIDS/STD): a) strategic projects with NGOs/civil society; b) fund-to-fund transfers to states and municipalities who include activities directed to indigenous health in their PAMs (planos de ações e metas); and c) transfers to DSEI/FUNASA through an intersectoral agreement to finance activities agreed in an Action Plan. Given that both FUNASA and the CN belong to the same ministry, no formal agreement is required.

History of response by the National STD/AIDS Program

The STD/AIDS National Coordinating Office (*Coordenação Nacional de DST/AIDS* – CN-DST/AIDS) began its work among indigenous populations in 1989. At that time, its operations were carried out jointly with the National Foundation for the Indian (*Fundação Nacional do Índio* – FUNAI), its main objectives being to train health sector professionals and support field research into STDs and AIDS. These activities were generally not carried out in a continuous fashion and

did not result in the creation of consolidated structures to support systematic prevention and treatment measures.

Starting in 1994, with the signing of the AIDS I loan agreement with the World Bank, under the umbrella of the PREVINA program, operations targeted at the indigenous population became more institutionalized and grew in scale, as awareness grew of the perilous health conditions afflicting indigenous peoples, together with evidence of localized STD epidemics. These activities, it should be noted, were conducted on case by case and emergency basis.

Not until the period 1996-98 did a concrete proposal emerge targeted at STD/AIDS prevention and treatment among indigenous peoples. Thus, a national response was developed, based on strengthening indigenous organizations and Indian support groups, with regularly scheduled and continued training of indigenous health agents, and the establishment of a specific forum for discussion of the issue of STDs and AIDS within indigenous communities.

One major problem in implementing the proposal was the fragmentation of indigenous health care activities between FUNAI and the National Health Foundation (*Fundação Nacional de Saúde* – FUNASA)[4] and the lack of communication between the health care systems coordinated by the two foundations. FUNAI responded with treatment and social support services, while FUNASA took responsibility for preventive measures, primarily control of malaria and other endemic diseases. This dichotomy gave rise to countless institutional conflicts and torpedoed the movement toward the establishment of a health care system geared to the realities of indigenous life, which had been the aim since the first National Conference on Protecting the Health of the Indian (*Conferência Nacional de Proteção á Saúde do Índio* – I CNPSI) in 1986, the First National Indigenous Health Forum (*I Fórum Nacional de Saúde Indígena*) in 1993, and the Second National Health Conference for Indigenous Peoples (*II Conferência Nacional de Saúde para os Povos Indígenas* – II CNSPI) in 1993[5]. There was no properly structured and coordinated system, making it difficult to gain access to treatment services under the Unified Health System (SUS). Access was difficult for a number of reasons: (a) long distances between SUS treatment centers from the communities; (b) health professionals were poorly prepared to cope with the indigenous peoples; (c) tardy application of the law establishing the DSEIs; (d) the indigenous health agents were poorly trained; (e) absence of specific programs (e.g. for STD/AIDS, reproductive health, or tuberculosis) established in the communities. Given the lack of a formal health structure at the time, the program gave its support to indigenous organizations and NGOs working in the area of indigenous health care.

Signing of the AIDS II loan agreement made it possible to consolidate the proposals envisaged earlier and gave new impetus to preventive measures. The current approach was changed, and the concept of vulnerability was adopted as the theoretical/operational reference point. This period was marked by the decisive influence of actions undertaken by CN-DST/AIDS in regard to Brazil's indigenous health policy. Starting with local organization of prevention campaigns, awareness was created for the formulation of an indigenous health policy led by the Ministry of

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[4] Athias, R & Machado, M.; " *A saúde indígena no processo de implantação dos distritos sanitários: discursos antropológicos e médicos*". Communication presented to the meeting of the Associação Brasileira de Saúde Coletiva, São Paulo, 1999.

[5] See the technical reports presented at: *I Conferência Nacional de Proteção à Saúde do Índio*, Relatório Final, Brasília, Ministério da Saúde, 1986.; *II Conferência Nacional de Saúde para os Povos Indígenas*, Relatório Final, Brasília, 1993; *I Fórum Nacional de Saúde Indígena*, Documento Final, mimeographed text, Secretaria de Estado da Saúde de São Paulo, 1993.

Health.[6] This process was only made possible by two significant steps: (1) publication of the draft Law 63/1997 authored by Sérgio Arouca; (2) Provisional Measure No. 1911-8/1999, which transferred responsibility for the health of indigenous peoples to FUNASA. This period was marked by a number of sectoral conflicts, both inside and outside the government apparatus. It was also a period of direct conflict between indigenous peoples and homesteaders (*posseiros*), illegal miners (*garimpeiros*), mining companies, dam builders and with federal and local government authorities.[7]

The strategy pursued by CN-DST/AIDS changed with the establishment of the Special Indigenous Health Districts (DSEIs), and began to place priority on coordination with FUNASA in order to strengthen local response, with the establishment of DSEI-based STD/AIDS prevention and treatment programs. Support for projects began to be directed toward issues regarded as of strategic importance, with priority focus on measures targeted to young people, Indian women, and groups living in border areas. Assistance measures are being carried out jointly with FUNASA.

Access to Preventive, Diagnostic and Treatment Services for Indigenous Peoples:

Prevention: Preventive services are provided by the DSEI organizations and involve five strategic lines of action: (1) mobilization of the community and its leadership on the issue of HIV/AIDS and other STDs; (2) training of indigenous health agents and other professionals working within the DSEI to spread information on reproductive health, sexually transmitted diseases, and counseling and guidance on HIV antibody testing; (3) training of teachers and students at indigenous schools in health promotion techniques, particularly in regard to reproductive health and prevention of STDs and HIV/AIDS; (4) intersectoral linkages with other parts of the government involved in indigenous affairs; and (5) support for strategic projects in areas of increased vulnerability and risk.

With regard to the mobilization of indigenous peoples, special mention should be made of the work of the District Councils and of the Inter-Institutional Committee on Indigenous Health (CISI) within the National Health Council (CNS). These social monitoring bodies have been the designated address for requests and complaints from the sector, while also serving as important actors in formulating policy proposals for the health sector. The AIDS committees of the states and municipalities have also played an important role in representing the social monitoring function. Proper linkages between decision-making bodies and programs in the area of indigenous health are needed to avoid duplication of effort and overlapping decision-making in STD/AIDS matters. This segment of the population is also served by the National Conference on Indigenous Health (*Conferência Nacional de Saúde Indígena*), a strategic body for defining national policy guidelines. The Third National Conference on Indigenous Health is to be held in May, and for the first time STD/AIDS will be included on its agenda.

With strategic projects, the object is to link together a network of stakeholders and institutions with the aim to reduce the epidemic's impact on the most vulnerable and endangered groups, namely: (a) indigenous reserves that have been invaded by outsiders or are close to where mining

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[6] Brasil: "*Política Nacional de Atenção á Saúde dos Povos Indígenas*." Ministério da Saúde, Brasília, December 2000.

[7] Varga Van Deursen, I & Adorno, R.C.F, "*Terceirizando a indianidade? Sobre a política nacional de saúde para os povos indígenas, aos 500 anos*." Mimeographed text, Universidade São Paulo, Faculdade de Saúde Pública, 2001.

operations are taking place, including informal mining operations (*garimpos*), together with woodcutting operations, large-scale farming and livestock projects, and dam and highway construction sites; (b) indigenous communities within urban areas; (c) indigenous communities located in border areas; and (d) impoverished communities.

Strategic projects are those more especially designed to improve the situation of populations not covered by ongoing prevention and treatment campaigns and who also find themselves at a social, cultural and epidemiological disadvantage in coping with the HIV/AIDS epidemic and other STDs. Also classified as strategic are those projects designed to encourage the development of sound practices and innovative technologies in the areas of prevention and treatment. The partners in developing these projects are indigenous organizations, non-governmental organizations active in indigenous affairs, state and municipal level STD/AIDS coordinating offices, and the DSEIs.

Projects supported and resources deployed: Twelve projects, representing an investment of BRL 338,000 for indigenous peoples, were supported in 2002. These projects are viewed as strategic by the National Coordinating Office (CN) as they are designed to subsidize the implementation of specific STD/AIDS programs. The decline in the number of projects for this segment of the population is justified by the fact that programs of this type are being incorporated into the DSEIs, as recommended by the National Conference on Indigenous Health.

All of the projects listed below are preventive in nature, encompassing the training of indigenous health agents in community intervention activities, promoting awareness among community leaders and traditional healers, organizing young people and women, and guaranteeing access to condoms. The projects include direct representation of community leaders. The Coordinating Office does not give the project its final approval until it has been endorsed by the indigenous community.

Support for STD/HIV/AIDS Prevention within the Indigenous Health Program, 1998 to 2002

Product	1998/99	Coverage	2000	Coverage	2001/2002 January to July	Estimated coverage for the year 2001/2002	Major results achieved - STD/HIV/ AIDS
1 – Project support	1998 - 27 projects 1999 - 17 projects	97,702 Indians (30.2%)	10 projects	N= 323,000 193,800 (60.0%)	15 projects	N= 350,000 258,400 (74.0%)	See situation report
2 – Educational materials	1 video (02 tapes) 1 STD/ AIDS manual 1 serial album	32 DSEIs (100%) 27 CE-AIDS (100%) 100% of cooperating NGOs	1 directives document	100% DSEI 100% NGO 100% CE	1 textbook		

3 –Working offices for establish-ment of STD/AIDS programs in the DSEIs					3 regional offices	1 regional office	

HIV testing: Under the AIDS II project, a proposal to monitor the course of the AIDS epidemic and other STDs among indigenous peoples was developed in conjunction with FUNASA, based on an analysis of areas of greatest vulnerability and highest risk, on the basis of the indicators mentioned earlier. A surveillance model was drawn up that took account of the cultural characteristics and differences among each of the tribal groups. It was agreed that measures would be taken to monitor the HIV situation among pregnant women, and patients diagnosed with STDs and with tuberculosis. Implementation of this project was dependent on approval of the use of quick tests by ANVISA. Access to testing for indigenous peoples is guaranteed through the CTAs (testing and counseling centers – *centros de testagem e aconselhamento*), but testing is still in an early phase and is not yet being conducted on a regular basis. There is a proposal to train the DSEI teams to enable them to guarantee and expand access to these quick tests as a diagnostic tool.

Access to Treatment and Care. As regards access to treatment for individuals suffering from STDs and living with HIV/AIDS, we should like to stress two points: (1) basic care and prevention services are provided by the DSEI units, in the form of training for health care professionals in setting up programs using the syndromic approach, and also in the form of training for indigenous health agents, teachers and community leaders in the areas of education and community health promotion; (2) as regards secondary and tertiary care, referrals are made to the SUS (Unitary Health System), via SAE (Specialized Outpatient Services – *Serviços Ambulatoriais Especializados*), ADT (Home Therapeutical Care – *Assistência Domiciliar Terapeutica*), and the credentialed hospital network. These services receive specially earmarked funds for treating the indigenous population.

Responsibility for basic care and treatment rests with FUNASA, while CN-DST/AIDS is charged with providing guidelines with regards to the establishment of services and standardizing procedures and routines. The CN provides training of health care professionals in the syndromic approach to STDs, together with training in counseling, training of indigenous health agents in developing prevention campaigns and specific educational materials. With regard to access to anti-retrovirals and monitoring of pregnant women, the DSEIs send their requests to the SAEs, which in turn register the patients and continue to monitor them in conjunction with the technical staff of FUNASA. In regions where distances between the community and available services make access difficult, the National Coordinating Office has been mobilizing other sectors, such as the Armed Forces medical services.

Major challenges and lessons learned: The program faces the following challenges: (1) to reduce the current levels of rotation of health professionals within the DSEIs; (2) finalize the process of coordination of state and/or municipal programs with the DSEIs in order to implement specific actions targeting indigenous peoples on the basis of criteria established by the National Coordinating Office (CN) and FUNASA; (3) reduce barriers relating to access to services, testing

and treatment in conformity with cultural and tribal differences; and (4) guarantee additional resources to keep strategic projects going.

We would list the following successes: (1) integration at the national level of the work agendas of FUNASA and CN-DST/AIDS; (2) development of culturally appropriate educational materials in various indigenous languages; 3) progress in the process of creating programs within the DSEIs; (4) monitoring of major trends in the epidemic among the indigenous segment of the population; and (5) coverage based on enhanced vulnerability and risk as the relevant criteria.

As regards NGOs carrying out direct activities among indigenous peoples, it is important to note that many of these organizations have no experience working with STD/AIDS, making it necessary for them to strengthen the capacity of their teams; in addition, the NGOs have frequently come into conflict with the communities, with resultant interruptions in work programs. For these reasons, the National Coordinating Office has preferred to work with recognized indigenous organizations and Indian support groups and to strengthen the response capability of the Indians' own organizations.

III – Plan of Action:

Objectives:

1 – Improve the local management process and encourage the programming of joint actions by the DSEIs and local STD/AIDS administrators;

2 – Mobilize additional human and technical resources to train DSEI health teams;

3 – Strengthen the task force to monitor the establishment of STD/AIDS programs within the DSEIs;

4 – Prioritize prevention and treatment measures aimed at members of the indigenous population living in urban areas, through strategic measures coordinated with state and municipal authorities and non-governmental organizations;

5 – Establish a joint plan of action for assistance measures between FUNASA and the National Coordinating Office, by defining guidelines, priorities, flows and counter-reference for STDs and HIV/AIDS; and

6 – Establish instruments to match, at the local level, information collected by the Indigenous Health Care Information System (*Sistema de Informações da Atenção à Saúde Indígena* – SIASI) and the Reportable Diseases Information System (*Sistema de Informações sobre Agravos Notificáveis* – SINAN), in order to reduce the underreporting of STD and HIV/AIDS cases among the indigenous population.

Indigenous Development Plan:

- Support for behavioral modification projects and health campaigns being executed jointly with non-governmental organizations, indigenous organizations, and Indian support groups, to train indigenous health agents and teachers as disseminators of information;

34 projects/year (at least one project in each DSEI) = BRL 5,100,000.00 for the three years covered by the AIDS III Project

- Organization of macroregional meetings to define STD/AIDS prevention strategies, promote social monitoring in the health area, and mobilize the indigenous peoples, by bringing together the health care institutions making up the Unified Health System (SUS), FUNAI, non-governmental organizations, and institutions representing the indigenous communities;

7 meetings/year (21 meetings over the 3 years of the project) = BRL 630,000.00

- Basic and advanced training of indigenous agents and Indian schoolteachers as information disseminators to help develop prevention programs in indigenous communities;

12 training courses (4 in each year of the project) = BRL 600,000.00

- Guaranteed supply of needed inputs (condoms and quick tests) to develop preventive measures for health in general and STD/AIDS in particular;

Included in the general project total

- Conducting of seroprevalence studies in selected (sentinel) sites to identify the risk situation and exposure to HIV/AIDS and syphilis among segments of the indigenous population at greater risk and/or with heightened vulnerability;

1 seroprevalence study = BRL 120,000.00

- Production of technical documentation and instructional material to assist in intervention measures among the indigenous community;

Included in the general project total for Information, Education and Communication (IEC)

- Reduction in the prevalence of STDs within indigenous communities by providing support to DSEI technical staff and training physicians and nursing staff in a syndromic approach to STDs.

30 courses on the syndromic approach over the 3 years of the project = BRL 900,000.00

- Sustainability of preventive measures and of the civil society institutions carrying out the intervention projects. For this component, meetings will be held with the administrative agencies (Coordinating Offices at the national, state and municipal levels, together with FUNASA) to discuss the inclusion of "additional funds" to finance the prevention campaigns for indigenous peoples at PAM medical posts, and to guarantee financing through indigenous health care.

It is important to emphasize that, in every stage of preparing this plan of action and the strategies to be employed, the CN-DST/AIDS has included representative organizations of the Indians themselves, both in the social monitoring bodies mentioned earlier, and in committees and advisory groups. The resources should include counterpart funds from FUNASA for training activities and administration of STD/AIDS programs within the DSEIs.

Potential Monitoring Indicators:

Number of NGOs working with Indigenous Peoples.
Number of indigenous people covered.
Amount of financing allocated to Indigenous services.
% of those municipalities with indigenous populations that included activities for indigenous health in their PAMs.
No. of indigenous health agents trained.
Prevalence of AIDS amongst indigenous people.
Prevalence of STDs amongst indigenous people.

SITUAÇÃO DAS DST NOS DSEIs EM 2001

Incidência Conhecida de DST por DSEI - DESAI 2001				
DSEI	No CASOS		Pop	Inc./1000hb
	DST	HIV		
1 - Alto Rio Juruá	231	0	7 068	32,7
2 - Alto Rio Purus	220	0	5 644	39,0
3 - Alto Rio Negro	114	0	27 372	4,2
4 - Alto Rio Solimões	2	2	28 190	0,1
5 - Manaus	209	0	11 108	18,8
6 - Médio Rio Purus	28	0	3.380	8,3
7 - Médio Solimões	38	0	6.710	5,7
8 - Parintins	100	1	7 984	12,5
9 - Vale do Javari	42	0	2.585	16,2
10 - Leste de Roraima	25	0	29 910	0,8
11 - Yanomami	20	0	13.398	1,5
12 - Porto Velho	67	0	6.041	11,1
13 - Vilhena	32	0	4 784	6,7
14 - Altamira	255	0	1 677	152,1
15 - Guamá/TO	36	0	3.693	9,7
16 - Kaiapó - PA	1	0	3.263	0,3
17 - Rio Tapajós	29	0	4.985	5,8
18 - Amapá e Norte do Pará	115	0	5.821	19,8
19 - Tocantins	30	0	6.945	4,3
20 - Maranhão	681	0	19 021	35,8
21 - Ceará	257	0	8.119	31,7
22 - Potyguara	64	0	9 701	6,6
23 - Pernambuco	753	0	27 038	27,8
24 - Alagoas e Sergipe	1	0	6.997	0,1
25 - Bahia	0	0	14 988	0,0
26 - Minas Gerais E Santo	160	0	9 212	17,4
27 - Litoral Sul	19	0	3.500	5,4
28- Interior Sul	360	0	28.995	12,4
29 - Araguaia	101	0	2.535	39,8
30- Cuiabá	159	0	4 521	35,2
31 - Kaiapó - MT	0	0	2.948	0,0
32 - Xavante	28	0	9 910	2,8
33 - Xingu (*)	276	0	3 982	69,3
34 - Mato Grosso do Sul	367	0	42.098	8,7
Total	4 820	3	374 123	12,9

(*) XINGU DADOS FORAM DIVIDIDOS DE 2000-2001

DSEIs COM CASOS DE HIV/AIDS NOTIFICADOS - 1998 a 2001

1	1 - Alto Rio Juruá - AC	
2	2 - Alto Rio Purus - AC / AM	
3	3 - Alto Rio Negro - AM	
4	4 - Alto Rio Solimões - AM	02
5	5 - Manaus - AM	02
6	6 - Médio Rio Purus - AM	
7	7 - Médio Rio Solimões - AM	
8	8 - Parintins - AM / PA	
9	9 - Vale do Rio Javari - AM	
10	10 - Leste de Roraima - RR	03
11	11 - Yanomami - RR / AM	
12	12 - Porto Velho - RO / AM	
13	13 - Vilehna - RO / MT	
14	14 - Altamira - PA	
15	15 - Guamá Tocantins - PA	
16	16 - Kaiapo - PA	01
17	17 - Rio Tapajós - PA	
18	18 - Amapá e Norte de Pará - AP / PA	02
19	19 - Tocantins - TO	
20	20 - Maranhão - MA	
21.	21 - Ceará -CE	
22	22 - Potiguara - PB	01
23	23 - Pernambuco - PE	01
24	24 - Alagoas e Sergipe - AL / SE	01
25	25 - Bahia - BA	01
26	26 - M Gerais e Esp Santo - MG / ES	01
27	27 - Litoral Sul - RJ / SP / PR / SC / RS	01
28	28 - Interior Sul - SP / PR / SC / RS	
29	29 - Araguaia - GO / MT	03
30	30 - Cuiabá - MT	
31	31 - Kaiapó - MT	
32	32 - Xavante - MT	
33	33 - Parque Indígena do Xingu - MT	
34	34 - Mato Grosso do Sul - MS	24