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Permanent Forum on Indigenous Issues
Economic and Social Council
Second session, 12-23 May 2003, New York

COMMITTEE ON INDIGENOUS HEALTH

Report No. 3

Agenda Item 4 c

HEALTH

Briefing Report on HIV/AIDS in Indigenous Communities

Recommendations

1) That the Global Fund and UNAIDS be requested again to be part of the Inter-Agency Support Group and thereby acknowledge indigenous issues, indigenous peoples rights and the unmet needs of indigenous health in their programmes. The Permanent Forum had made a similar recommendation in its first report in 2002.

2) That the Global Fund is requested to review their funding strategy in order to include access by Indigenous NGOs who are most qualified to respond to the prevention and treatment needs of Indigenous communities and nations. Additionally, access to funding through initiatives like the Declaration of Commitment, UNICEF's HIV/AIDS programs and other relevant agency programs need to be made available to Indigenous peoples beyond the scope of government-controlled programs.

3) That UNAIDS and other relevant UN programmes responsible for gathering information on this disease include Indigenous experts and research initiatives that are designed to gather current data on the impact of HIV/AIDS among our communities and their reproductive health world-wide.

4) That UNAIDS, a major sponsor of the International AIDS Conference, recommend that the organizers give particular precedence to Indigenous experts, scientists, doctors, traditional leaders and community activists working with HIV/AIDS in Indigenous communities. We would also recommend that UNAIDS use its influence to ensure the inclusion of plenary sessions, presentations and workshops in this regard.

5) That regarding indigenous peoples reproductive health, recommend to WHO, UNICEF and UNAIDS for:

- More formative research to understand the beliefs, knowledge, attitudes, and practices of indigenous youth to better design projects and interventions.
- Careful evaluation of interventions and strategies that demonstrate what works and what does not work.
- Documenting and supporting wider dissemination of experiences to advance the field.
- Advocacy at the local and national levels to awareness about the issues of indigenous youth.
- Increased indigenous ownership of programs to catalyze involving indigenous communities and youth in the design, implementation, management, and evaluation of projects. Parents, community leaders, and teachers to be included in these processes, and ~~they~~ must be sensitized to the needs of young people, including reproductive health

needs. Programs should also be holistic, user-friendly, easily accessible, and culturally appropriate. When these steps are put into practice, projects should be more sustainable and successful.

- Existing reproductive health education materials, training, and programs should be adapted specifically for indigenous audiences and translated into the appropriate languages using indigenous staff, and field-testing the content with indigenous populations.

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1. In a joint USAID/UNICEF/UNAIDS Report on orphan estimates and program strategies called Children on the Brink (2002) it was stressed "that young people are at the centre of the HIV/AIDS epidemic: they are both the hardest hit by the disease and also the key to overcoming it. Yet despite this, strategies for responding to the epidemic generally disregard young people." Nowhere is this absence of strategy more obvious than in Indigenous communities worldwide.

2. Geographic and cultural isolation limit the indigenous youth's access to health education and prevention services, including reproductive health services. This group is less likely to receive curative care for Sexually Transmitted Infections (STIs), including HIV and conditions that can affect the outcomes of pregnancy and delivery. In peri-urban areas of Guatemala and some areas of Thailand, young indigenous girls are involved in prostitution that leads to higher rates of sexually transmitted infections (STIs) and HIV/AIDS. Widespread alcohol and drug abuse among indigenous communities is an important co-factor in the high rates of HIV and STIs among the youth. Because of persecution, many indigenous people fear and mistrust outsiders and are suspicious of services.

3. Indigenous youth face the same barriers to reproductive health services that other youth face; however, they encounter additional obstacles because of their indigenous roots. Many face social and institutional discrimination and may be reluctant to use available reproductive health services. Indigenous people often dwell in less accessible places, such as the mountainous regions of Asia and the rainforests and mountains of South and Central America. If they are poor and live in a rural area, access to services may be limited. If they live in urban areas, they may face problems with acculturation issues and discrimination. Many indigenous youth, especially girls, speak only their native language and find it difficult to conduct themselves in the mainstream culture. They are more comfortable with their own health belief systems, traditional providers, and treatments than with Western medicine. Together, these and other conditions make indigenous youth a group with a large unmet need for reproductive health services.

4. *"Throughout history, Indigenous women have interacted with other Indigenous women through various women's societies. Traditionally, the matters pertaining to women were the business of women. All decisions concerning her reproductive health were left up to a woman as an individual; her decision was respected, and was final. Oftentimes an Indigenous woman would turn to other women within her society for advice, mentoring, and assistance concerning reproductive health."* ("Empowerment

Through Dialogue," an Agenda for Native Women's Reproductive Rights; 1990). Yet, this vital role of indigenous women in the health of their communities, including our children's and youth's health, is being severely undermined through dispossession and destruction of indigenous lands, displacement by so-called development projects and programmes, disempowerment and non-inclusion in all the decision making levels of healthcare services.

5. Historically, diseases brought by outsiders, both willingly and unwillingly, have been allies in the conquest of our peoples and to avoid a repeat of this tragic situation immediate action must be taken. The Committee on Indigenous Health is spearheading an initiative to include and respond to Indigenous needs with respect to the pandemic of AIDS. This initiative is contained in the attached document entitled the "Barcelona Initiative" which was presented at the most recent XII International AIDS Conference held in Barcelona, Spain in July 2002.

6. At the beginning of the 21st century, Indigenous Peoples and our right to survival and well being continue to be under serious threat, with most of the governments of the world refusing to recognize, respect, protect and promote our fundamental human rights to health, to cultural knowledge, practices and identity, to land, to self-determination and to the unique lifeways of indigenous peoples. This inequity is obvious in most responses to the affects of HIV/AIDS in Indigenous communities worldwide and, though NO specific international statistics exist for Indigenous peoples, the markers show that women and children are most susceptible. In the developing world, and in Indigenous communities everywhere, low per capita income, dramatic inequities in income distribution, and poor healthcare infrastructure, make it difficult or impossible to provide high quality modern medical care to those who need it most. For Indigenous peoples, this is true whether one lives on a reservation in South Dakota or in the remote North Eastern region of India. The statistics regarding HIV/AIDS do not discriminate and is one other thing we, as Indigenous peoples, have in common with our brothers and sisters around the world.

- As of December 2002, there were 42 million people worldwide living with HIV/AIDS. In 2002, there were 5 million new infections of HIV and a total of 3.1 million deaths.

- In sub-Saharan Africa ten million young people (aged 15–24) and almost 3 million children under 15 are living with HIV.

- Every 14 seconds, a child loses a parent to AIDS. Whole nations are being weakened by this disease.

- In the United States, two new HIV infections in people ages 13-25 occur every hour.

- It has been estimated that at least half of all new HIV infections in the United States are among people under 25 years. HIV related death has the greatest impact on young and middle aged adults, particularly racial and ethnic minorities.

- Worldwide, young people between the ages of 15 and 24 account for the majority of new HIV/AIDS infections. Intravenous drug use accounts for much of the infection. This statistic is particularly relevant to Indigenous communities

where centuries of oppression and colonization have resulted in outrageously high levels of substance abuse. For example, in the United States, death rates from alcoholism are 627% higher for Indigenous peoples than the rest of the population.

- In Asia, as many as six million people are infected with the HIV virus, more than the total number of persons elsewhere in the entire industrialized world.

- In the next decade, in high HIV prevalence countries like Cambodia, Thailand and a few states in Indian, annual AIDS deaths will increase the total annual death in the 15-49 year-old population by up to 40%.

- In Asia, it is estimated that more than 500.000 individuals died of AIDS in 2000 and that this number will reach about 800.000 by 2005. The highest number of deaths is expected to occur in China, India, Burma (Myanmar) and Thailand, in regions most populated by Indigenous peoples. In North Eastern India, Northern Burma and Northern Thailand, indigenous communities are internationally recognized as particularly hard-hit by the HIV/ AIDS epidemic.

- In Myanmar, where HIV/AIDS is recognized as the three top communicable diseases, UNAIDS just began operations this year in April after 3,817 AIDS cases were reported and 510,000 HIV infections were estimated by the end of 2000.

- Sub-Saharan Africa is now home to 29.4 million people living with HIV/AIDS. Approximately 3.5 million new infections occurred there in 2002, while the epidemic claimed the lives of an estimated 2.4 million Africans in the past year.

- Globally, fewer than 4% of people in need of antiretroviral treatment in low- and middle-income countries were receiving the drugs at the end of 2001. In Africa, by far the hardest hit, only a tiny fraction of those infected are receiving anti-retroviral treatment.

- Less than 10% of people with HIV/AIDS have access to palliative care or treatment for opportunistic infections.

- There are no statistics available specifically addressing Indigenous peoples in the area of treatment availability, but given the empirical evidence, we can be sure it is lower than the 4% cited for the developing world.

- Further evidence of the diseases impact on Indigenous peoples can be found in the developed world. In the United States, the epidemic has shifted into poorer and marginalized sections of society, including Native Americans. African-Americans accounted for an estimated 54% of new HIV infections in 2000 (but constitute only 13% of the population of the United States).

- According to a 2002 CDC report, AIDS-related illnesses remained the leading cause of death in the US for African-American men aged 25–44 and the third-leading cause of death for Hispanic men in the same age group.

- About 64% of the women diagnosed with HIV in 2001 in the United States were African-American.

- In Canada, Aboriginal persons accounted for 9% of new HIV infections in 1999, although they constituted less than 3% of the general population. Obviously these trends in communities of colour can be projected to affect Indigenous peoples in North and South America, New Zealand and Australia.

- Current projections suggest that an additional 45 million people will become infected with HIV in 126 low-and middle-income countries (currently with concentrated or generalized epidemics) between 2002 and 2010. More than 40% of those infections would occur in Asia and the Pacific. Again, the impact on Indigenous communities in those regions could be devastating, but no projections exist.

4. The United Nations and its relevant agencies have been taking many steps to address this global crisis of HIV/AIDS. The UN General Assembly convened a special session on HIV/AIDS a couple of years ago, and adopted a Declaration of Commitment establishing time-bound targets to which the Untied Nations and member states can be held accountable. UNICEF is developing global, regional and national strategies to deal with the growing threat to young people through its Life Skills initiatives. The Global Fund to Fight AIDS has approved an initial round of project funding of $616 million, about two-thirds of which is for HIV/AIDS. There have also been extensive regional efforts in Africa, Asia and the Caribbean.

5. However, most of these efforts do NOT include the specific needs of Indigenous peoples. In the United States, we have long struggled against the inadequate and non-existent reporting mechanisms for Indigenous peoples. In other regions, such as Asia and Africa, Indigenous peoples are just too overwhelmed with multiple health crises to struggle collectively on this issue. Without adequate statistics, it is impossible to respond appropriately. In researching this intervention, no statistics on indigenous peoples were included in the breakdowns. At the last International AIDS Conference there were no workshops on HIV and Indigenous peoples and only a few poster presentations.

6. The current decision by the Global Fund to distribute funding only to countries or organizations sanctioned by the Country Coordination Mechanism (CCM), instead of regional and local community health care systems, which are more knowledgeable about how to target funding, only ensures that discrimination in funding and access will continue. Most governments, in whose territorial limits Indigenous peoples live, have failed to compile disaggregated information on the socio-economic or cultural situation in Indigenous communities. This has been regularly mentioned in WHO's annual reports with regard to the Decade on the World's Indigenous Peoples.

7. In last year's report to the Permanent Forum on Indigenous Issues, the Pan American Health Organization (PAHO), the regional office of WHO, stated that they implemented an Indigenous Health Initiative in 1993. Thirty-five countries participated in their study on Health of the Americas, but unfortunately PAHO relied on the countries to provide information, not Indigenous peoples, demonstrating an absence of the direct participation and input of Indigenous peoples.

8. Although regional cooperation and national initiatives are important steps, exclusion of tribal and Indigenous communities from the process ensures that we will not have access to effective strategies. This is especially true within Indigenous communities who have been oppressed and dominated for centuries by ruling governments and a natural

distrust of efforts from outside the community has developed. For example, the decision by the Global Fund to distribute funding only to countries or organizations sanctioned by the Country Coordination Mechanism (CCM), effectively eliminates community-based prevention and treatment initiative in Indigenous communities.

9. In our work in Native communities in North America surrounding HIV/AIDS we have found that peer-sponsored strategies are by far the most effective. Excluding our own people from the prevention and treatment process only ensures that discrimination in funding and access will continue.

We would therefore make the following recommendations to the Permanent Forum:

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Thank you

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