SOCIO-CULTURAL ANALYSIS

IMPROVING THE HEALTHCARE SYSTEM OF SURINAME

Final Report

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List of Abbreviations

ACT	Amazon Conservation Team
BOG	Bureau of Public Health
CBO	Community-based Organization
CD	Communicable Disease
CP	Consultation Platform
ESAV	Indigenous Platform
FPIC	Free and Prior Informed Consent
GoS	Government of Suriname
IDB	Inter-American Development Bank
ILO	International Labor Organization
IP	Indigenous Peoples
MMC	Mungra Medical Centre
MoH	Ministry of Health
MSD	Malaria Service Delivery
MZ	Medical Mission Primary Health Care
NCD	Non-Communicable Diseases
NGO	Not-for-Profit Organization
NIMOS	National Institute for Environment and Development in Suriname
RGD	Regional Health Service
OIS	Organization of Indigenous Peoples in Suriname
OP	Operational Policy
PAHO	Pan American Health Organization
PHC	Primary Health Care
PMU	Project Management Unit
SZF	State Health Care Provider
TRIJANA	Trio and Wayana Indigenous Organization
UNDP	United Nations Development Program
UNDRIP	United Nations Declaration of the Rights of Indigenous Peoples
VIDS	Association of Indigenous Leaders in Suriname
VSG	Association of Saramacca Maroon Leaders

Executive Summary

The Ministry of Health (MoH) of the Republic of Suriname is seeking a loan to be financed by Inter-American Development Bank (IDB) for the purposes of improving the functioning of the health system in the country. As part of this objective, the MoH wants to fund the current program on improving treatment to communicable diseases (CD) in order to sustain and improve the country's response to CDs. As part of the preparatory activities for this loan, we conducted a socio-cultural analysis for the project to effectively address communicable diseases and health disparities for indigenous peoples (IP) and maroons.

IP and maroons live remotely in rural areas or in the difficult to access interior of Suriname. These tribes (partly) rely on the forest and use traditional knowledge to collect food, construction materials, and medicinal plants to sustain themselves. Especially the Maroons engage in extraction activities (gold mining, logging) as a source of income. Elders can rely on a small government pension premium, which is an important source of income for IP/maroon families because jobs in the rural areas and the interior are scarce due to the low level of development. IP and maroons may have only narrow understanding of knowledge types other than traditional knowledge they have gathered through experience, which lowers their chances to participate in the money economy.

The IP and maroons use healthcare services in the villages they live in. These services are less compared to the coastal region in terms of i) types/amount of services available, ii) access to emergency care and iii) access to specialized healthcare. The Medical Mission (Medische Zending-MZ) delivers healthcare services through 50 permanent health clinics and 167 healthcare workers in the interior, relying on 50+ year experience with designing and delivering care programs for IP and maroons. The Malaria Service Delivery (MSD) Network provides health services with 24 healthcare workers to migrant populations working in the remote gold-mining areas. The proposed healthcare program builds on these two structures.

Legal Analysis: The UNDRIP recognizes indigenous peoples and maroon' rights to access healthcare without discrimination, as well as the right to use traditional healthcare practices. Indigenous peoples and maroons also have the right to be actively involved in developing healthcare programs. Although MZ is currently piloting with a permanent consultation forum with IP and maroons, provisions on effective inclusion of IP/maroons need to be considered in the proposed healthcare program (see separate consultation plan). In addition, the IDB operational guidelines state that IP should be protected against any harm from a project implemented in their lands. The existing national laws and practices aren't specific enough to protect indigenous peoples and maroons against medical waste infections.

Vulnerability analysis: IP and maroons are vulnerable to discrimination because of several factors: i) limited understanding of others about the special rights of IP/maroons, ii) distinct worldview and languages, 3) lack of inclusion laws on IP/maroons, iii) limited political power of IP/Maroons and 5) low access to capital by IP/Maroons. The vulnerability of IP and maroons increases with the internal problems they are facing, such as the low poverty level, the ongoing acculturation of the tribes and the existing division between the groups, which is reflected in the numerous organizations representing IP and maroons.

*Impact analysis: R*isks were identified using a qualitative analysis based on the social baseline assessment and the consultation with the IP/maroon stakeholders. With the limited legislation and low power position of IP and maroons, there is a moderate risk for discrimination and associated grievances may end up in an international claim. Risk related to mismatching the program with the cultural traditions and values of IP/maroons is moderate. The storage of waste in lands where IP/maroons live can create a risk of infection of these populations. There is a moderate risk for stigma and exclusion of infected tribal members by their own group.

The study concludes with a set of actions to mitigate the risks identified. Discrimination should be prevented by have equal access to quality services as the coast and to also hire IP/Maroons in the healthcare program. The program should also ensure adequate cultural appropriateness of the proposed program, healthcare personnel should undergo training on IP/maroons traditions, values and healthcare systems, and develop specific programs for women, elderly and youth. Indigenous peoples and maroon can be supported with a chaperone program for families to accompany the sick when they travel to Paramaribo and a psychological support program, for people who are depressed or mentally unstable. Infection of hazardous waste should be thoroughly discussed with the IP/maroons in a process of Free and Prior Informed Consent, while waste management practices should improve on site where IP/maroons live.

1. Introduction

1.1 Improving the Health System in Suriname

The Republic of Suriname, specifically the Ministry of Health (MoH) is seeking a loan to be financed by Inter-American Development Bank (IDB) for the purposes of improving the functioning of the health system in the country and addressing more effectively communicable diseases, non-communicable diseases, and health disparities in vulnerable populations, and strengthening the functioning of the Ministry of Health. The proposed Operation would include the following components:

Component 1: Institutional strengthening of the MOH for evidenced-based policy-making (estimated US$12.37 million). This component seeks to improve the ICT and physical working environment platforms for the MOH to exercise core policy and technical functions.

Subcomponent 1.1. Improved eHealth ecosystem (estimated US$4.3 million). This component seeks to improve the eHealth ecosystem in Suriname. Based on findings from the needs assessment, this subcomponent will finance: (i) technical assistance for updates to policies, standards and interoperability; (ii) design and implementation of data warehouse and dashboards; (iii) improved ICT infrastructure including servers, connectivity and hardware; (iv) design and implementation of the integrated clinical information system for expansion of the CCM and its respective costed maintenance plan; (v) Implementation and analysis of two rounds of the STEPS survey; and (vi) design and implementation of disease registries for CKD and cancer.

Subcomponent 1.2. MOH headquarters and central services infrastructure (estimated 8.07 million). This will consist of improvement to the physical working environment for the MOH to perform its core business functions, enhancing productivity and hence a more effective management of the health sector´s priorities. All the MOH facilities will be concentrated in one site, located in Rode Kruislaan[1] which will be modernized to accommodate administrative and public health central services (i.e. vaccines, children with special needs, breastfeeding, health library). The works will include the reuse of abandoned/underused buildings and the construction of a new one, all incorporating green design criteria and climate change mitigation measures.[2] The subcomponent will finance: (i) the construction design of approximately 6,000m^2 and the landscape design of approximately 2.5 Ha; (ii) the retrofit of the existing buildings, new construction works and landscaping of the compound; (iii) the procurement of office furniture and equipment; (iv) the supervision of the construction works and; and (v) the design of a costed maintenance plan.

Component 2. Expansion of the CCM (estimated US$3.83 million). The objective of this component is to improve accessibility and quality of clinical pathways for non-communicable diseases. It will support improvement and expansion of an integrated, patient-centered healthcare model for diabetes in the OSS of Paramaribo and Nickerie, and within approximately 28 RGD primary care facilities that already operate in these areas. Facilities will be selected based on results of a health care network demand and supply analysis. Financing will be provided for: (i) minor infrastructure upgrades and physical repairs; (ii) procurement of medical and non-medical equipment and supplies; (iii) design and implementation of a continuous quality improvement (CQI) strategy to optimize clinical

[1] The selected site is property of the GOS, currently used for MOH facilities and located in an urbanized area.
[2] Technical Analysis, financed with project preparation resources, provides details on the infrastructure project, including assessment of existing conditions, architectural brief, program of space requirements and design criteria.

and management processes related to the CCM; (iv) training of clinical personnel in core CCM protocols (ie. footcare) ; (v) design and implementation of innovative patient education and activation strategies; and (vi) initial operating costs of equipment improvements to the CCM.

Component 3. Increase access to priority services for communicable diseases in at risk population (estimated US$1.5 million). The objective is to sustain and improve the response to communicable diseases. This component will finance the following activities targeting the gold mining population: (i) design and implementation of culturally appropriate BCC strategies to reduce exposure to risk factors for malaria and HIV (ie. promoting use of bed nets, increasing health seeking behavior) and improve adherence to treatment by at-risk population; (ii) specialized training for the MP and National Reference Laboratory personnel; (iii) straining of MP personnel in BCC (iv) equipment upgrades for the national reference laboratory and TropClinic surveillance; (v) technical studies; and (vi) training and laboratory and field equipment for HIV screening.

Program Administration and Evaluation (estimated US$1.465). This budget line will support the operation of the PIU and project administration and evaluation activities, including the design and implementation of an impact evaluation.

1.2 Bank Policies

According to IDB's Operational Policy on Indigenous Peoples (OP-765), Indigenous peoples is a term that refers to peoples who meet the following three criteria: (i) they are descendants from populations inhabiting Latin America and the Caribbean at the time of the conquest or colonization; (ii) irrespective of their legal status or current residence, they retain some or all of their own social, economic, political, linguistic and cultural institutions and practices; and (iii) they recognize themselves as belonging to indigenous or precolonial cultures or peoples.

Indigenous people and maroons in Suriname fall under this category. However, small-scale miners from Brazilian origin don't follow this definition.

For activities and operations not specifically targeting indigenous peoples but of potential benefit to them, the Bank will adhere to the following policies:

- Identify and target indigenous peoples that could potentially benefit;
- Implement socio-culturally appropriate and effective consultation processes with these peoples;
- Respect the traditional knowledge, cultural heritage, natural assets, social capital, and the systems specific to indigenous peoples with respect to social, economic, linguistic, spiritual and legal systems;
- Adapt services and other activities to facilitate access to them by indigenous beneficiaries, including equitable treatment, and, whenever feasible, adequate procedures and criteria, and programs for capacity-building and compensation of exclusion factors; and (
- Design complementary measures and activities through a process of good faith negotiation with indigenous affected communities.

These policies will be guiding this study:
Environmental and Safeguards Compliance Policy (OP-703)
Operational Policy on Gender Equality in Development (OP-761)
Operational Policy on Indigenous Peoples (OP-765)

1.3 Study Objective

The objective of this consultancy is the prepare, research and write a socio-cultural analysis for the project for improving the health system in Suriname by addressing more effectively communicable diseases, non-communicable diseases and health disparities for indigenous peoples and maroons. The socio-cultural analysis focuses on mitigation measures as well as socio-cultural appropriateness and inclusiveness of the project. This study serves as a reference for the implementation of activities and services and should comply with national legislation as well as the IDB safeguards policies listed above.

The study focused on the indigenous and maroon communities in the project's area of influence and included the following tasks:

1. Analysis of the Legal Framework on indigenous peoples, identifying the main international conventions and agreements ratified and subscribed to by Suriname, the principles and guidelines established in the Operational Policy on Indigenous Peoples of the IDB (OP-765).
2. Gather and compile a detailed Social Baseline for the Direct and Indirect Area of Influence of the works, activities, equipment or services to be financed, with new field information. This will include an analysis of the culture of each one of the communities or main indigenous groups in the country, the world view, practices, livelihood of each, including demographic data, income, education, and analysis of the traditional leadership structure of each one, and representatives of each indigenous Community. The consultancy will cover local governance (forms of community organization and local organization, existence of traditional indigenous authorities or other authorities in the community, etc.) and complaint mechanisms and mechanisms for decision-making.
3. Analysis of Social Vulnerability. Situation of the indigenous population in the area of the Operation according to their levels of socioeconomic and cultural vulnerability.
4. Analysis of Social Capital of the communities: analyze cultural heritage, traditional life systems, of food, social protection and collaboration, holistic health practices and others, that could support as mitigation measures against any negative impact of the Operation.
5. Population Expectations: aspirations, perception, and attitudes within the indigenous communities toward the activities, works, equipment or services being proposed.
6. Community Structure and Institutional Functioning: norms, values, customs, behaviors and mechanisms for decision making that have been institutionalized through inter and intra-group relations, relevant for the works, material, equipment or services of the Operation, including an analysis of the legitimate leaders of the communities, such as for example political leaders, traditional leaders, midwives, religious leaders, or leaders of other kinds like women's groups that are responsible for the Community.
7. Gender Aspects: identify areas and activates in which women should participate equally with men. These include public consultations, economic activities, access to services and benefits of the Operation, etc.
8. Sociocultural Aspects: characterization of values, customs, aspirations and attitudes of the community towards the attention and services of the health system, and how these related to the Operation and the works, materials, equipment or services it finances.
9. Analysis of possible impacts generated by the presence of construction workers. Analyze the possible risks associated with the construction of the building to serve as the Ministry of Health headquarters, with particular emphasis on the behavior of the employees of the contractors in their interactions with the community, and possible negative gender impacts including sexual harassment or violence towards women or children in the community.

10. Cultural changes or generational disruption: Analyze the internal cultural changes and tensions that could be generated or identified as a result of the works, materials, equipment, or services of the Operation, in the context of the changes that could be introduced.
11. Analysis of other risks and possible negative social impacts, including direct, indirect, accumulative, induced and/or residual conflicts in indigenous communities.
12. Consultation Plan with Indigenous Communities. Based on the community structure and institutional functioning, including the traditional and political structure of decision-making, the consultant will elaborate a Consultation Plan for the indigenous communities to be intervened in, that are culturally appropriate, and which reflect the requirements established in the Operational Policy on Indigenous Peoples (OP-765) of the IDB. Some provisions to take into account in the case of consultations with indigenous communities, is that they should be culturally appropriate, preferably using one or more facilitators belonging to or well-versed in the culture and/or language of the respective Community, ensuring that those community members who don't speak English or Dutch have the opportunity to ask questions and express opinions and concerns; that the consultations are held at a time and in a space which are both accessible to the local indigenous population, particularly for vulnerable groups within the community like women, youth, the elderly, and disabled people, and that the decision-making mechanisms of the indigenous community are respected and honored. The first round of consultations should take place during the preparation of the Operation and this consultancy will support that process in form and content. Thereafter, the Executing Agency should continue communications with the indigenous communities in an ongoing manner.
13. Indigenous Peoples Plan. Include the specific measures for the indigenous communities that should be implemented to ensure that the activities to be financed by the Operation, including equipment, materials or services, will be socio-culturally appropriate and inclusive. This Plan and the measures included in it should have an estimated Budget, tentative timeline, responsible parties and other logistical details that will help to implement it.
14. Monitoring of Sociocultural Aspects. Definition of socio-cultural indicators that serve as baseline for the monitoring of changes generated by the new works, materials, equipment or services to be financed by the Operation, defining a monitoring system for the indigenous communities.

During the study, the IDB adjusted the terms of reference according to the project needs.

1.3 Methodology

In consultation with the IDB, the following project components were identified as relevant for analyzing the socio-cultural impact on indigenous and maroon peoples:

- Predesign of a new building construction for MoH. A small population of maroons live approximately 400m from the proposed building site.
- Improved programs for communicable diseases: Gold mining-related migrants were identified as vulnerable populations which should have better access to healthcare for CD.

The methodology for study consisted mostly of desktop research supported with field survey data. We propose the following methodologies for the different tasks.

1. *Field data gathering*: We used the Rapid appraisal technique Sondeo. The Sondeo is a method of learning about local peoples' situations, experience problems and perspectives directly from the peoples themselves. It generates insights and information rarely obtained in a formal survey in a relatively short period of time. The Sondeo can encourage community participation in problem diagnosis and planning and verifying what is known. By involving communities actively throughout the process, it provides a contrast to traditional research in that data is not merely extracted and disseminated.

2. *Desk-top study and supplemental pre-consultation*: Information was gathered through studying existing reports, publications and documents. Additionally, IP and maroon organizations and experts were contacted for their viewpoints on the project. We also used case studies to conduct the analysis and develop the indigenous and maroon peoples' plans.

1.4 Study Outcome and Limitations

This study was conducted during the pre-design phase of the proposed healthcare project. Currently, specifications on the areas of the proposed project and programs are still undefined. This study gives a general understanding of the context in which IP and maroons exists in healthcare, and specific considerations about the proposed project.

One of the limitations of this study is that it was conducted in a short time and covered many different topics of indigenous and maroon people's socio-cultural context. The consultant, Gwendolyn Smith Ph.D., relied on her 15+ year experience working with indigenous and maroon peoples, as well as report and publications. The lead consultant was supported by Dunja Burkhard M.Sc. (Social Geography) and Melvin Uiterloo M.Ph. (Public Health).

Because of the short time-frame, the team was unable to conduct extensive interviews with IP, also because it takes more time to consult with tribes. Our work limited us to a hearing some views about the project. We therefore propose additional consultation activities with the IP, as explained in the separate report in the consultation of IP/Maroons.

2. Legal Framework on Indigenous and maroon Peoples' Healthcare in Suriname

2.1 International laws and guidelines related to Indigenous and maroon Peoples

2.1.1 UN Declaration of the Rights of Indigenous Peoples

The intention of Suriname, as one of the signatories to UNDRIP (2007), is to recognize indigenous peoples and maroons people as a group different from the rest of its population and create a legal framework to protect the rights of this group. The foundation of this treaty concentrates on four interrelated areas:

1. The indigenous peoples are clearly a separate group than mainstream society with their own customs and convictions. This includes collective and individual rights.
2. The indigenous people are recognized as having an older right to land than others because of the treaties made by their ancestors.
3. The right to self-determination: the indigenous peoples have the right to freely determine their political status and freely pursue their economic, social and cultural development.
4. Free prior and informed consent (FPIC). It allows indigenous peoples to give or withhold consent to a project that may affect them or their territories. Once they have given their consent, they can withdraw it at any stage. Furthermore, FPIC enables them to negotiate the conditions under which the project will be designed, implemented, monitored and evaluated.

The UNDRIP is instrumental in protecting indigenous groups' health and wellbeing for the proposed project, in the following provisions:

Access to Healthcare

- Traditional medicine: Indigenous peoples have the *right to their traditional medicines and to maintain their health practices,* including the conservation of their vital medicinal plants, animals and minerals.
- Discrimination: Indigenous individuals also have the *right to access, without any discrimination, to all social and health services*. In addition, the project should take measures for indigenous individuals to have an equal right to the enjoyment of the highest attainable standard of physical and mental health. States shall take the necessary steps with a view to achieving progressively the full realization of this right (Article 24).

Development of Healthcare Programs

- Improvement of health: Indigenous peoples have the right, without discrimination, to the improvement of their economic and social conditions, including health. The project shall take effective measures and, where appropriate, special measures *to ensure continuing improvement of their economic and social conditions*. Particular attention shall be paid to the rights and special needs of indigenous elders, women, youth, children and persons with disabilities (Article 21).
- Health programs: Indigenous peoples have the *right to be actively involved in developing and determining health* programs affecting them and, as far as possible, to administer such programs through their own institutions (Article 23)

Hazardous Waste

This article states that indigenous and maroon peoples have the right to the conservation and protection of the environment and the productive capacity of their lands or territories and resources. This article is applicable for the storage and transportation of hazardous waste from testing on sites in lands belonging to indigenous and maroon peoples. The proposed project should take effective measures to ensure that *no storage or disposal of hazardous materials takes place in the lands or territories of indigenous peoples without their free, prior and informed consent.* The project shall also take effective measures to ensure, as needed, that programs for monitoring, maintaining and restoring the health of indigenous peoples, as developed and implemented by the peoples affected by such materials (Article 29).

Participation

- Participatory process: The project shall establish and implement, in conjunction with indigenous peoples concerned, *a fair, independent, impartial, open and transparent process*, giving due recognition to indigenous peoples' laws, traditions, customs and land tenure systems. Indigenous peoples shall have the right to participate in this process (Article 27).
- Cultural sensitivity: Indigenous peoples have the *right to the dignity and diversity of their cultures, traditions, languages, histories and aspirations* which shall be appropriately reflected in education and public information (Article 15/16).
- Discrimination: The project should take effective measures, in consultation and cooperation with the indigenous peoples concerned, to combat prejudice and *eliminate discrimination and to promote cultural diversity, tolerance, understanding and good relations* among indigenous peoples and all other segments of society (Article 15).
- Representation: Indigenous peoples have the right to *participate in decision-making in matters which would affect their rights, through representatives chosen by themselves* in accordance with their own procedures, as well as to maintain and develop their own indigenous decision-making institutions (Article 18).
- Local institutions: Indigenous peoples have the right to *maintain and strengthen their distinct political, legal, economic, social, and cultural institutions, while retaining their right to participate fully*, if they so choose, in the political, economic, social, and cultural life of the State (Article 5).

2.1.2 ILO Convention on Indigenous and Tribal People in Independent Countries no.169

The ILO convention no.169 regulates different aspects regarding the rights of indigenous people; from policy, recruitment and conditions of employment, healthcare, education and communication to land rights. Suriname has neither signed or ratified this treaty, and therefore we refrain from examining this treaty in great detail. Yet, the ILO 169 is relevant to discuss because the indigenous groups and organizations in Suriname frequently use it as a reference.

With regard to healthcare, is the ILO 169 more specific than the UNDRIP. It gives more concrete provisions on the right to develop their own health programs and have access to medical institutions, health services and medical care. ILO 169 regulates the mandate that health services should be community-based with the following provisions:

- Governments shall ensure that adequate health services are made available to the peoples concerned or shall provide them with resources to allow them to design and deliver such services

under their own responsibility and control, so that they may enjoy the highest attainable standard of physical and mental health (Article 25.1).

- Health services shall, to the extent possible, be community-based. These services shall be planned and administered in cooperation with the peoples concerned and consider their economic, geographic, social and cultural conditions as well as their traditional preventive care, healing practices, and medicines (Article 25.2).

2.1.3 Human Right Treaties

Suriname has ratified several treaties on human rights which has provisions that are applicable to indigenous and maroon people's rights as outlined below (Table 2-1).

Table 2-1: Ratified human rights treaties by Suriname

Treaty	Provisions applicable to indigenous peoples
International Convenant on Civil and Political Rights (1966)	Right to self-determination (Article 1)
	In those States in which ethnic, religious or linguistic minorities exist, persons belonging to such minorities shall not be denied the right, in community with the other members of their group, to enjoy their own culture, to profess and practice their own religion, or to use their own language (Article 27)
International Convenant on Economic, Social and Cultural Rights (1966)	Right to self-determination (Article 1)
	Everyone is entitled to an adequate standard of living (Article 11)
International Convention on the Elimination of all forms of Racial Discrimination (1966)	Recognize and protect the rights of Indigenous people to own, develop, control and use their communal lands, territories and resources and where they have been deprived of their lands and territories traditionally owned or otherwise inhabited or used without their free and informed consent, to take steps to return these lands and territories
American Convention on Human Rights (1969)	Article 1, imposes upon the State parties to comply with obligations under the convention, and in doing so guaranteeing all citizens of the States the enjoyment of the rights and freedoms from the convention. No distinction may be made as to race, color, sex, language, religion, social background, economic status, etc. This means that the Indigenous people and the Maroons just as other citizens have to enjoy the rights and freedoms from the convention
Caricom Charter of Civil Society (1995, non-binding)	States recognize the contribution of the Indigenous people to the development process and that the States intend to continue with protecting their historical rights and respecting the culture and the way of living of these people.

2.2 National Laws and Guidelines related to Indigenous Peoples

Historically, indigenous and maroon communities have lived in the interior rainforest, characterized by a permanent or semi-permanent subsistence lifestyle. The interior progressed virtually independent from the better-developed coastal area where more than 85% of Suriname's population resides. This geographic divide resulted in two separate legal systems: the national judicial system in the coast and the traditional law system in the interior.

2.2.1 The Suriname Constitution

The Constitution of Suriname has specific provisions against discrimination of indigenous peoples, as part of provisions for all peoples living within the territory of Suriname. The Constitution states in Article 8.2 that "No one shall be discriminated against on the grounds of birth, sex, race, language, religion, education, political opinion, economic position or any other status".

Beside the legal provisions in the constitution, policy makers and executives adhere to a general practice of keeping balance between the different ethnic groups. Especially in Government, decisions are being made to keep all groups content and prevent choosing one over the other. Such practice is widely used and unwritten.

The judicial system is formed by laws and regulations vested in the trias politica doctrine. The Ministry of Health, as the highest executive body, derives authority from Suriname's constitution (Article 36) stating: Every citizen has a right to health.

2.2.2 National Healthcare Laws and Guidelines

The State of Suriname promotes public health through systematic improvement of living- and working conditions and shares information to raise awareness about health. The Ministry of Health (MoH) has a framework of existing laws which regulate healthcare all over the country. However, National laws on healthcare don't recognize or have specific provisions for indigenous peoples.

Healthcare for indigenous and maroon peoples is administered by two permanent entities who have different geographic jurisdiction:

1. *The Regional Health Service (RGD) of the Ministry of Health, which* operates through clinics in Paramaribo and the coastal rural areas.
2. *The NGO Medical Mission (MZ), which* operates through clinics in the difficult accessible interior of Suriname.

Both entities deliver healthcare based on Primary Health Care principles, which implies a comprehensive approach in addressing people's basic health needs.

Besides the RGD and MZ, the MoH targets mobile migrant populations for Malaria infections. Border regions and gold mining fields are designated as high-risk areas for Malaria. At these sites, tests are available to individuals, which include indigenous communities. The Malaria program relies on the National Prevention and Treatment Protocol and the Malaria Guidelines to deliver its services. The protocol gives medical directions for malaria prevention, therapy and specific guidelines for pregnant women, while the guidelines give instructions to health workers how to prevent, diagnose, treat and report Malaria in order to eliminate the disease in 2020.

The MZ and Malaria health care services possess several aspects that demonstrate respect for the rights of indigenous peoples. Table 2-3 makes a comparison with the Suriname Constitution, the IDB Operational Guideline 765 on Indigenous Peoples and the UNDRIP.

2.2.2 Indigenous Healthcare Regulations

Indigenous healthcare practices are currently unregulated, although there are ongoing discussions at the Ministry of Health about regulating traditional practices, as part of a new law on intellectual property (spearheaded by the Ministry of Justice).

Yet, indigenous populations practice traditional health in several locations in the interior and the coast. Internal practices are regulated by customary rules instituted by the tribal authorities in close collaboration with the medicine men/women delivering the service. These rules are mostly about ethics (selection of patients, payment/benefit sharing, spiritual healing) and vary between communities.

2.2.3 Guidelines for Tribal Engagement

Suriname laws lack specific provisions on participation of indigenous peoples. Usually participation of local peoples is facilitated on two levels: 1) the State council, a set of experts, provides advice to the proposed laws, and 2) if a law enters in parliament, the political representation of the citizens of Suriname can engage in the debate and decision-making based on majority vote. However, indigenous and maroon peoples only represent a minority (approximately 22%) of the 51 representatives in Parliament.

Because of the international verdicts Suriname has received in the past, the GoS, private companies and NGOs have become careful about overstepping the rights of indigenous peoples. In this regard, in March 2016, in a project funded by the United States Department of State and commissioned by Conservation International, UNDP and the National Institute for Environment and Development (NIMOS), representatives of the Saramacca maroon group (VSG) and representatives of indigenous peoples (VIDS) developed a strategy for the Government of Suriname (GoS) on how to engage tribal peoples in general development processes. The strategy provides an overview of the principles and process for tribal engagement, and these are presented below. The basic principles for effective tribal engagement are outlined in Table 2-4.

Whenever the GoS wants to engage with a community and execute a project, it should be according to the following process:

- *Appointment*. Make an appointment with the traditional leadership of the community.
- *Information sharing*. Share information on the proposed project. This includes a general discussion of the idea, after which the community identifies the priorities for their own development. This phase ends with a discussion about the content and execution of the proposed project.
- *Decision-making.* Consider enough time for the community to assess risks, threats and opportunities before the start of the project and during execution of the project. Explain the process thoroughly, including the parts where community input is required.

Table 2-3: Relevant provisions currently addressed in the Malaria and MZ healthcare programs program

Provision	Constitution of Suriname 1987 no. 166	IDB Operational Guideline 765	UNDRIP	Malaria Program	MZ Healthcare System
Discrimination	No one shall be discriminated against on the grounds of birth, sex, race, language, religion, education, political opinion, economic position or any other status	Eliminate barriers to benefits/services. IP should receive the same protection as other peoples. Assure equal opportunity for proposals submitted by IP	The project should eliminate discrimination and to promote cultural diversity, tolerance, understanding and good relations among IP	No specific provisions	No specific provisions
Cultural sensitivity	No specific provisions	Respect for traditional knowledge, cultural heritage, social capital and linguistic, legal and spiritual systems	IP have the right to the dignity and diversity of their cultures, traditions, languages, histories and aspirations	Communication in language of target population (Dutch, Surinamese, English and Portugese)	Practical, scientific sound and social acceptable methods and techniques
Hazardous waste	The State shall promote general health-care by a systematic improvement of living and working conditions and shall give information on the protection of health.	The Bank will conduct its operations in a way that prevents or mitigates direct or indirect adverse impacts on indigenous peoples or their individual or collective rights or assets.	Ensure that no storage or disposal of hazardous materials takes place in the lands or territories of indigenous peoples without their free, prior and informed consent.	Paramaribo: National waste management protocol based on WHO guidelines Interior: Self-designed protocol for waste management	Paramaribo: National waste management protocol based on WHO guidelines Interior: Self-designed protocol for waste management
Participation	No specific provisions	Implement culturally appropriate and effective consultation process	A fair, independent, impartial, open and transparent participatory process. IP have the right to the dignity and diversity of their cultures, traditions, languages, histories and aspirations which shall be appropriately reflected in education and public information	Continuous awareness and community engagement of target population in outreach activities	Community participation and education of the community on prevention of illness

Provision	Constitution of Suriname	IDB Operational Guideline 765	UNDRIP	Malaria Program	MZ Healthcare System
Access to healthcare	Every citizen has a right to health	Adapt activities to facilitate access of services by IP	IP have the right to their traditional medicines and to maintain their health practices. IP have the right to access, without any discrimination, to all social and health services	Malaria Service Deliverer network (MSD) works at local level in high-risk areas	Primary health care system characterized by uniformity, attainableness/sustainable, affordable by both the provider and the receiver
Development of health programs	No specific provisions	Activities and operations should address the needs and development of IP. Adapt services to increase availability and quality of services by development of own systems, articulation of traditional elements and training for IP staff	The project shall take effective measures and, where appropriate, special measures to ensure continuing improvement of IP's economic and social conditions. IP have the right to be actively involved in developing and determining health programs affecting them and, as far as possible, to administer such programs through their own institutions	Community members (e.g. shopkeepers, taxi drivers) are trained to diagnose malaria using rapid diagnostic tests	The health care is being provided by health assistants of different schooling levels with a clear-cut level of responsibility. The greater part of the health assistants are persons from the local community, who have been trained by the Medical Mission MZ is piloting with a consultation platform with IP and maroons

- *Monitoring, evaluation, verification and validation*. Build in frequent monitoring and evaluation meetings. Validate and verify outcomes together with the community on set times.
- *Conflict resolution.* Develop conflict resolution strategies to manage and resolve conflict e.g. neutral and independent mediation and other interventions.
- *Exit strategy and sustainability.* Plan for exit strategy and sustainability of project at the beginning of the project. Enable community empowerment for continuing projects.

The project should follow these guidelines when engaging indigenous peoples.

Table 2-4: Basic principles for effective tribal engagement designed for the Government of Suriname

	Basic Principle	**Details**
1	Respect	Equally respect the ideas of the community to enable partnership
2	Ownership and leadership	Promote ownership by collaboratively designing projects in a bottom-up fashion based on existing structures, support local decision-making processes, enable accountability and leadership of the community over the project
3	Capacity building and empowerment	Include capacity building in all parts of the project, enable long-term thinking for local empowerment, establishment of community development funds and corresponding structures for management, led the community lead the project with a supporting role from intervener
4	Rights-based approach	Result of the project should be based on human rights. The project should enable capacity building of the community on human rights
5	Information sharing, communication and transparency	Use appropriate language, prior inform community thoroughly using simple and understandable terms, repeat difficult information, gather feedback from the community to see if message has been understood, consider the community's access to communication channels (TV, Internet, radio etc.).
6	Participation	Provide resources for the community to effectively participate in all parts of the project, enable functional and equitable participation
7	Trust	Be open, honest and transparent. Stay in frequent contact with the community
8	Cultural sensitivity	Try to understand the community before starting a project. Build on existing community structures and mechanisms. Avoid being judgmental (based on western values) or superior. Focus on collaborative efforts.
9	Gender	Conduct a gender analysis as part of a larger problem analysis. Enable participation of both men and women in each part of the process; design, execution. Use gender appropriate indicators for monitoring and evaluation.
10	Age	Enable participation of elders and youth in each part of the process; design, execution. Assess risks on different age groups.

2.3 Conclusion

In conclusion, the analysis shows that the proposed healthcare program, implemented through the Malaria program and MZ, should take specific provisions to comply with the OP-765 and the UNDRIP requirements.

Discrimination: Suriname lacks specific provisions about discrimination in its healthcare programs although the Constitution promotes non-discrimination and equality in access to healthcare. Because of this gap, the IDB should pay special attention to monitoring this aspect.

Participation: Provisions on participation of IP and maroons are not present. The IDB project should do an extra effort to ensure a socio-cultural sensitive and effective consultation process with IP ensuring transparency, capacity building and their right to information.

Development of Health Programs: Although there are efforts being piloted to include IP in the design of programs (MZ), a structural protocol does not exist on how to develop programs in a dialogue with the IP and maroons. The project should actively involve IP to include their needs and increase the quality of services by including traditional systems and elements and training IP for delivery of services.
Hazardous waste: Current regulations on waste management don't provide sufficient protection for IP and maroons.

The recommendations in this section will be incorporated in Chapter 5.

3. Socio-cultural Baseline

3.1 General Introduction

Suriname is situated on the Northeastern coast of South America, bordered by the country of Guyana to the west, French Guyana to the east and Brazil to the south. Topographically, Suriname is divided into three main areas: the northern coastal lowlands, a central savannah region and southern highlands characterized by tropical rainforest referred to collectively as the “hinter- land” or the “interior”. Suriname is geo-politically divided into ten districts (Figure 3-1).
The northern coastal area, which is the most populous area, includes the districts of Nickerie, Coronie, Saramacca, Wanica, Paramaribo, Para, Commewijne, and Marowijne. The central savannah region and forest region house the districts of Sipaliwini and Brokopondo.

Figure 3-1: Map of districts Suriname

3.2 Demography and Population

Suriname has a total land area of 163,820 square kilometers and a total population of 541.638 inhabitants. Suriname has a relatively low population density of 3.3 persons per km².
Suriname shows an unequal spatial distribution of the population. The northern coastal region, which makes up only 10% of the total land area of Suriname, inhabits 91.8% percent of the total population. The Sipaliwini district covers the largest area (79,9%) but its population density is only 0.3 persons per km². According to the Bureau of Statistics, the country's population growth rate was 9.9% between 2004 and 2012.

Suriname is home to a variety of ethnic cultures. Besides the indigenous peoples, all peoples are (descendants of) migrants, who came either forced or voluntary in the past 500 years.

- The Creoles and Maroons are descendants of African slaves and constitute to 15.7% respectively 21.7% of Suriname's total population.
- The Hindustani (27.4%), Javanese (13.7%) and Chinese are descendants from indentured laborers from respectively India, Indonesia and China.
- Other ethnic groups consist of mixed race (13,4%); Chinese migrants; Brazilian migrants who arrived in Suriname from the early 1990s onwards to work in the gold industry, as well as their descendants. Smaller groups arrived from elsewhere: the Caribbean, Netherlands. Libanon and others.

No official statistical data was found on their exact numbers, but they approximately account for 4.6% based on a national census held by the Bureau of Statistics in 2012.

Among the most marginalized groups in Suriname are the original inhabitants of Suriname: The Indigenous people. According to the latest census (2012), the total number of Indigenous persons living in Suriname is 20.344 which accounts for 3,8% of the total population (Table 3-1). Also belonging to the most marginalized, but fastest growing groups in Suriname, are the much larger Maroon population accounting for 21,7% of the total population. Only a portion of the total number of Indigenous and Maroons belong to "forest-dependent communities". Studies from 2007 indicate the number of these "forest-dependent" persons to approach approximately 8000 Indigenous peoples and 54.000 Maroons.
The largest district of Sipaliwini is inhabited for most part by Indigenous and Maroon peoples. Many of these communities can be found in the districts of Brokopondo (Maroons), Marowijne and Para.

3.3 The Indigenous and Maroon tribes in Suriname

3.3.1 Indigenous Peoples

Indigenous peoples live in the 40 Indigenous villages. From a geographical perspective, the indigenous peoples of Suriname can be categorized in "coastal" indigenous peoples (occupying the coastal zone) and "southern" indigenous peoples (occupying the southern rainforest).

The **coastal indigenous peoples** consist of the Lokono (Arowak) and the Kaliña (Caraib). These tribes have long been sedentary, living at the river mouths and along the beaches. A great percentage of their population now live in Paramaribo, where they have mingled with the urban population.

Table 3-1: Numbers of Maroon and Amerindian peoples in Suriname

District	Number of Maroon Peoples	Percentage	Number of Indigenous Peoples	Percentage
Paramaribo	38.450	32,7	4087	20,1
Wanica	18.039	15,3	1766	8,7
Nickerie	242	0,2	734	3,6
Coronie	18	0,02	15	0,07
Saramacca	172	0,2	1028	5,1
Commewijne	978	0,8	423	2,1
Para	5.210	4,4	5134	25,2
Marowijne	13.103	11,2	1673	8,2
Brokopondo	13.172	11,2	120	0,6
Sipaliwini	28.183	24	5364	26,4
Total	**117.567**		**20.344**	

Source: ABS, 2012

The remaining group continues to live in villages on the coastal plains. These IP's close proximity to the capital city has influenced them in terms of western culture, such as the market economy and technology.

The **Southern indigenous peoples** consist of the two largest indigenous groups in South Suriname: The Trio and Wayana (Table 3-2). In addition, several smaller tribes populate South Suriname including the Akuryo, Apalai, and Waiwai. Members of these minority groups live in the larger villages dominated by Trio and Wayana. The Trio (or Tarëno) people are a group of indigenous tribes from nomadic origin living in a large area in Northern Amazonia. They probably arrived in Suriname from Brazil in the late 17th century.

Geographically, the Trio and Wayana they are located in three drainage basins: in Suriname they are in the upper Sipaliwini-Corantijn and the Tapanahony-Palumeu basins, with Kwamalasamutu and Peleletepu as central settlements. The Trio, having descended from nomadic people and walk extensively for days and weeks across the region. In contrast the Wayana are known for being "river people" and most of their activities are concentrated along creeks and rivers. There settlements are located on the banks of the upper Tapanahony, Litani, Oelemari rivers. They arrived from Brazil in the mid-18th century and settled in Apetina, Palumeu, and Kawemhakan, with Apetina as a central settlement.

Since their arrival, the indigenous tribes have spread across southern Suriname for hunting, fishing, collecting, and other cultural and subsistence practices. Today, many have given up their ancient

lifestyle and instead cluster in these permanent villages. For many indigenous families, an important motivation to settle is better access to public services, such as schools and health care. In addition, missionaries have been pressing for permanent settlement to be able to reach a larger crowd.

3.3.2 Maroons

The Maroons are descendants of African slaves who escaped the plantations in the 17th and 18th centuries and established semi-autonomous tribal communities. The Maroon population consists of six tribes: the N'dyuka/Aukaners, the Saramaccaners, the Paramakaners, the Aluku/Boni, the Matawai/Matuariers and the Kwinti (Table 3-2). Members of these tribes live in villages along riverbanks in the interior and for a smaller part in the coastal area.

There are about 200 Maroon villages, most of which (approx. 150) are in the district of Sipaliwini. The tribes are situated along the rivers according to the following:

- The Ndyuka tribe has settlements located along the Tapanahony-, Lawa- and the Marowijne River, between Albina and Pakira Creek. Some smaller groups live along the Suriname River and near Sarakreek (in the Van Blommensteinmeer).
- The Paramaka tribe has settlements located along both sides of the Marowijne River. They have a strong trans-border relation with neighboring French Guiana (e.g. through trade).
- The Aluku tribe is mainly settled along both sides of the Lawa River.
- The Matawai tribe is settled along both sides of the Saramacca River with three main settlements, namely: Poesoegroenoe, Nieuw Jacobkondre and Kwakoegron.
- The Kwinti tribe has villages and camps along both sides of the Coppename River.
- The Saramacca tribe is mainly located along the Suriname River, (to some extent) in the Saramacca River and in the district of Brokopondo.

Figure 3-2 shows the geographical spread of both the Indigenous and Maroon tribes in Suriname.

3.3.3 Other Interior Inhabitants

The indigenous peoples and maroons have inhabited the interior for the last 150+ years, but in the last two decades, there has been an influx of Brazilian miners called Garimpeiros. These miners use simple technologies to extract surface gold from the rich deposits situated in the eastern part of the country, also called the Greenstone belt. An important characteristic of this group is that they are only stay at one place whenever the gold mining is profitable and tend to migrate through the interior.

The indigenous peoples and maroons facilitate Garimpeiros on their lands and are compensated for it. In most areas, they also provide support services in logistics and retail (shops, prostitution).

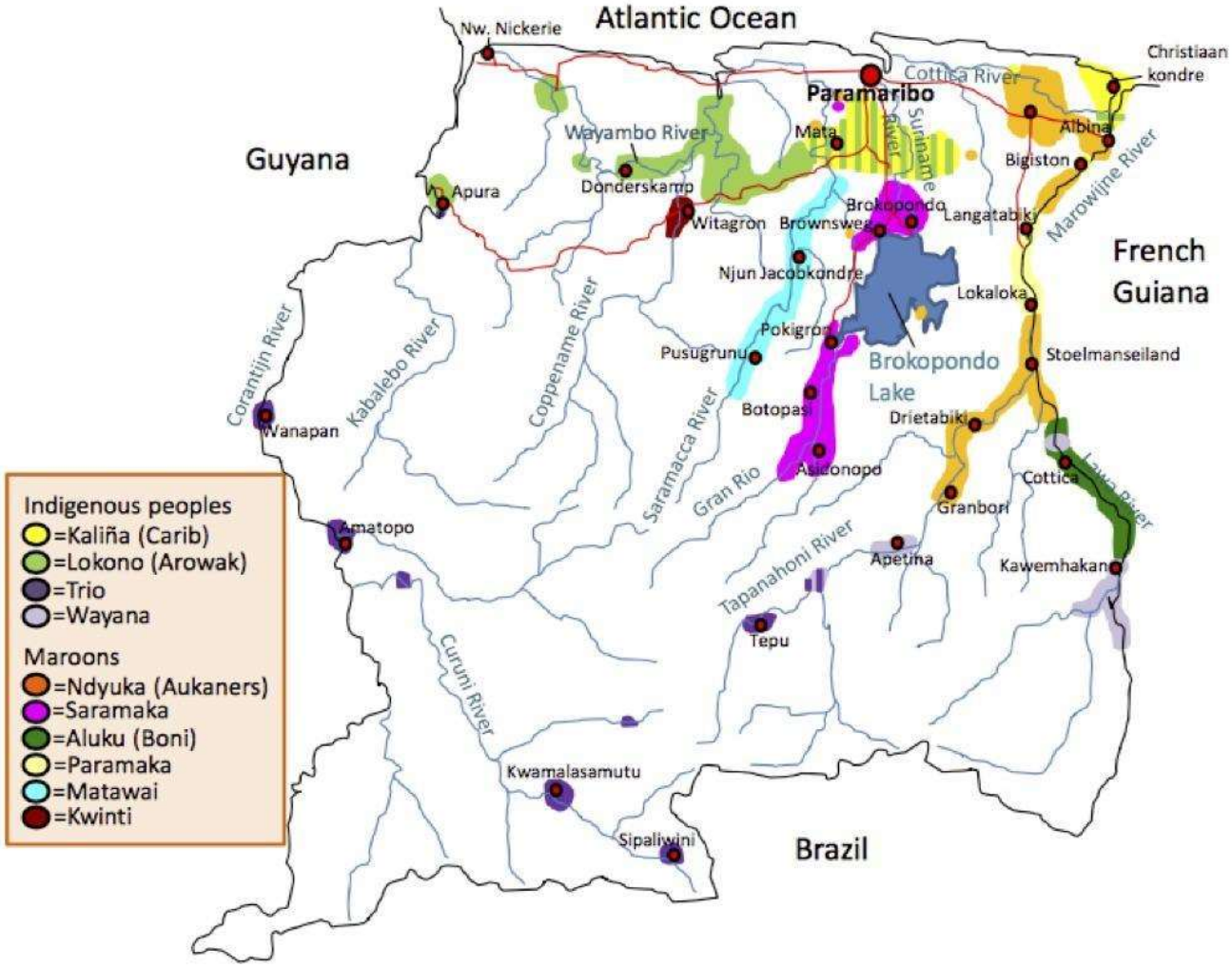

Figure 3-2: Indigenous and Maroon tribes of Suriname

Table 3-2: Numbers of "forest-dependent" Indigenous and Maroons in Suriname

Indigenous peoples		**Maroons**	
Kaliña (Carib)	2,500	Ndyuka (Aukaners)	20,000
Lokono (Arowak)	3,500	Saramaka	25,000
Trio	1500	Paramaka	4,000
Wayana	500	Matawai	3,000
		Aluku (Boni)	1,500
		Kwinti	500
Total	8,000	Total	54,000

Source: ACT, 2010

3.4 Indigenous Family and Household Structure

The specific characteristics of both indigenous and maroon kinship systems are particularly relevant to understand structures of power and decision-making, as well as participation of women.

Indigenous communities
Indigenous communities are generally described as uxorilocal. This uxorilocal characteristic means that the man settles to the part of the village where his wife, her female kin and related families reside. However, the last few decades this pattern has been changing and a number of exceptions are found throughout Indigenous villages. For example, men try to remain in their own village when he runs a family business with his father.

Traditionally, men have a more isolated position in the community because they are in-laws and not necessarily interrelated by kinship. Women are generally more depending on each other than men in their subsistence activities. Men and women differ (and complement each other) in the division of labor, in their social position in the family and ritual organization. Men have more access to cash money and therefore their position seems to change faster than women.

In general, indigenous settlements are organized around the households rather than focusing on collective community interests and services. For all indigenous groups of the region, the nuclear family is the most important productive and reproductive unit.

Maroon communities
Maroon communities are often described as matriarchal: the female line and matrilineal kin is the core of the community. The village of the mother is the place where the deceased are buried. Also, in times of trouble, Maroons are more likely to fall back on their mother's village for support.
Maroon societies are organized by the following family structures:

- the *ini osu* composed by the father, mother, children and grandchildren
- the *bee* composed by the descendants of matrilineal kin up to the sixth grade
- the *lo('s)*: with its origin in a shared group of slaves who escaped together from a certain plantation area and descendants of the female offspring of one shared female ancestor
- the *tribe* composing of matriclans with their most important characteristic being their shared dialect.

In most maroon communities, several lo groups are present. These lo groups are subdivided in various bee. People belonging to the same bee live together in a certain part ("pisi") of the village. The matrilineal kinship structure has considerable consequences for tribal and community life, amongst other things for social relations, settlement patterns, ownership of land and the division of political and religious functions.

3.4.1 Tribal Leadership, Organization and Appointment

On the level of socio-political organization, each Indigenous and Maroon village recognizes titled persons (traditional leaders) representing their villages. This system of traditional authority consists of several functions, with the highest being the 'granman' who is the paramount chief of a tribe. The chiefs are assisted by head-village chiefs called 'hoofd-kapiteins' and 'kapiteins' (village chiefs).

Maroons

In Maroon society, there are additional distinctions in leadership. Each (head) village chief represents a lineage (lo), an extended family (*bee*) or part of it. Most villages recognize two or three kapiteins. The chiefs and kapiteins are assisted by administrative assistants called 'basja' and by a council of elders, who represent the different matrilocal groups of a bee. Today, females haven't been chosen as granmans, but the functions of kapiteins and basjas can be fulfilled be either men or women. Among the southern Indigenous peoples, only men can fulfill the position of kapitein.

Among the Maroons, the functions of granman and kapitein are hereditary via the matrilineal line. The eldest son of the deceased granman's/kapitein's eldest sister holds preference for succession. Other matrilineal relations may also qualify, such as, the son of the mother's brother. Skills and power are also important factors meaning that succession is not always a straightforward process. A granman or (hoofd)kapitein is typically chosen from one and the same lo, though in some groups there are two lo that may provide the granman. The position of basja is often linked to the bee.

Indigenous peoples

Among the Trio and Wayana Indigenous peoples, traditional authority positions are preferably transferred from father to son. The departing leader extensively discusses the qualities he looks for with the community members in village meetings. A candidate must possess the following qualities: i) be trusted by different families, ii) be peaceful and not quarrelsome, and iii) be respected in the Baptist church – preferably as a Baptist minister, church singer, or confident. If no suitable person is found among the sons or other immediate family members of the deceased, the kapiteins and basjas may decide to pick someone else. This may even be someone from another sub-tribal group.

When traditional authorities have completed the internal process of selection, they nominate the candidate to the Ministry of Regional Affairs for a formal procedure of appointment. The candidate is nominated on the following criteria: ethics, meeting techniques, vision, role model and the ability to fulfill ceremonial functions on behalf of the tribe. The candidate is inaugurated by the Government through an official appointment (beschikking). The official appointment states the rank of the authority and area the candidate is governing. Official appointment gives a leader recognition from the Government; however, it doesn't specify that the leader is part of the Government system. The official instating of traditional authorities confirms they must obey national laws. Traditional leaders receive a stipend in their customary leadership functions, which are for basjas and kapiteins SRD300 (equal to U$40) and SRD600 (equal to U$ 80) per month, respectively.

The selection of a new granman or kapitein isn't always without dispute or conflict. Difficulty occurs when different families (in Maroon villages) may wish to place their own candidate in office. Such problems haven't been observed by indigenous groups who select traditional leaders from the single family-line. Discharge of a granman or kapitein is near to impossible (with exception of the Indigenous village of Bigi Poika) because traditional authority positions are for life.

For remotely living indigenous peoples in South Suriname, there are more challenges. The leaders have to travel large distances between villages and this is a challenge for centralized traditional leadership. As a result, village kapiteins tend to act rather autonomously from the granman. Also, the northern indigenous groups (Kaliña and Lokono) don't feature strong centralized leadership.

Role of Women

Maroons

In case a maroon leader dies, he is succeeded by one of his lineage members or appointed by members of one or more lo's. The position of granman (tribal leader) and captain (village leader) were occupied exclusively by men until 1995, 1998 and 2004 in respectively Aucaners, Paramaccaners and Saramaccaners regions. In those years, the first female captains were appointed under pressure from the Surinamese Government. The Government acted under pressure of international agencies to increase women participation on all political levels.

However, the female captain doesn't have the same jurisdiction as the male captains. Female captains have less authoritative rights and power. The female captain's activities or functions are restricted to the following:

- She can represent the tribal leader within the village
- She can represent the village and attend all meetings to which the leadership is invited
- She must resolve disputes in their village.
- She is supposed to preside over court sessions in their village and serve as a judge.

Female captains can't represent the ancestors of the village. Nor can they conduct rituals with the older ancestors (the Gaan Yooka Tiki), probably because of the menstrual taboo, which is said to have a negative effect on rituals and people involved. The appointment of the female captain has brought no significant change in women's role in formal public negotiations during tribal meetings (krutu's).

Female elders have a traditional role as: i) a medium for the spirits of late ancestors and include this in the formal decision-making processes, and ii) to share their view about important social matters. Women still depend on male elders to represent them and their needs in the decision- making process.

Indigenous peoples

So far, it has been impossible for women to fulfill the position of captain among the southern Indigenous peoples; only men can fulfill this position. The Wayana indigenous peoples have stated: "The Wayana traditional authorities of Apetina said there is no insurmountable objection against the appointment of female kapiteins; they just never found anyone suitable".
For the coastal indigenous peoples, the traditional rule that prohibits women to become a captain has changed and several female captains have been appointed.

In conclusion, with the relatively low power position of women, the influence from women through leadership is not expected to change soon. It is also important to mention that women empowerment doesn't come from within the tribe and is often promoted by outside influences.

3.4.2 Tribal Governance and Decision-making

Governance

Together the traditional authority manages the socio-political affairs of their respective village and its subunits such as representation to the outside, giving advice, arbitrating disputes, carrying out ritual

ceremonies and organize village income. These or other affairs concerning the village are usually discussed in village meetings or so called 'krutu's' with (or among) the traditional leaders.

Among both the Indigenous and Maroon peoples, daily governance and organization are dealt with on the village level by the kapiteins, basjas and village elders. The kapitein receives the jurisdiction from the granman to make customary laws in the area that he/she governs. The area is usually defined by the families that are the primary (historical) inhabitants of the area. However, the customary laws made by kapiteins can never be contradictory to those laws made by their granman.

Family level issues tend to be dealt with within each family. Decision-making may take days of gatherings or krutus. The content and relevance of the issue determines whether the krutus are held within the family, the village, a few villages, or at the residency of the granman. Usually the krutus are open to the entire group of interest. Traditional authorities and elders facilitate these meetings, but usually anyone may speak out. Decision making is based on consensus and should ideally avoid conflict and disputes. The most important decisions or stands are typically decided upon during smaller meetings. Decision making is democratic in the sense that the entire group of interest has a chance to participate.

On the other hand, matrilineal succession rules reduce the power of democracy. In addition to dealing with daily issues, traditional authorities are responsible for safeguarding the wellbeing of tribal members. Traditionally, this role included the redistribution of resources to ensure that the weakest in the community would have enough to eat. Reciprocal and caring relations form the social fabric of subsistence-based communities in the interior, and the traditional authorities are (or were) responsible for maintaining these structures.

Decision-making

With traditional leadership issues such as the use of an authority position for self-enrichment and for favoring the well-being of the immediate family group are common. Among the both the indigenous and maroon tribes, for example, various customary leaders, including the granman, are running a store or have other jobs/income sources. However, it is important to notice here that in such cases it is common for a traditional leader to have other means of income, because the stipend they receive for their function is insufficient for him/her to support their families. It also is common practice that close family members are being pushed forward for jobs from the Government and NGOs, regardless of their capacity.

With increased integration into the national economy, it can be observed that some leaders are forfeiting their social caretaking role and instead use their privileged position for betterment of only their own kin group. Such behavior has led to diminished respect for traditional leaders, and a lesser willingness of especially youngsters to listen to them. For example, when traditional leaders obtain mining concessions and allow for Garimpeiros (Brazilian small-scale gold miners) to work on this concession against a percentage share. A common trend found in indigenous and maroon villages, is that youngsters are disappointed in their traditional leaders, and these leaders complain that young people no longer want to listen to them. This trend is largely an (indirect) outcome of closer integration into the national economy and society. Youngsters, who become western educated and want to be part of the urban life, may feel that customary rules are old-fashioned and traditional leaders out of date.

3.5 Livelihood and Skills

Livelihood

The tribal groups in Suriname engage in a combination of traditional livelihoods as well as cash generating activities such wildlife trade (several species of birds, frogs and turtles), wood logging and (for Maroons) small-scale gold mining. Traditional livelihoods are based on shifting cultivation or slash-and-burn agriculture, fishing, hunting and harvesting timber and non-timber forest products, and medicinal plants for subsistence. The main staple foods are cassava and rice, and a wide variety of tubers, vegetables, and fruits, including: maize, sweet potatoes. Some income is also derived from the small number of tourists visiting the communities.

A small percentage of the population in Maroon and Indigenous villages are employed by the Government of Suriname. This includes among others functions such as for the Ministry of Public Works (e.g. janitors) or for the Ministry of Education (teachers). The villages that are situated closer to the coastal area (and thus close to the road network) are in the position to apply for wood cutting licenses and community forests, however, in practice the revenues from these often don't reach the communities. The southern villages, which are only accessible with boats and/or airplane have limited opportunities for trade and rely on the selling of bush meat, non-timber forest products and commercial agricultural products.

Changing lifestyles, clustered settlement pattern, and rising life expectancies are affecting the sustainability of traditional subsistence strategies. Indigenous peoples and maroons complain that they now must travel longer distances from their home villages to find land that is suitable for agriculture. Individuals who can't travel far tend to shorten the fallow periods of abandoned fields closer to home, which are exhausting soils permanently.

Most interior groups have come to rely on goods and services from the coast. Indigenous and maroon families increasingly consume canned and other processed foods; rely on shotguns for hunting, tools, plastic ware, and other manufactured assets bought on trips to the city area or in supermarkets nearby. On the other hand, the villages located further in the interior have maintained a larger degree of cultural, socio-economic and political autonomy from the State. These are mostly indigenous villages that depend almost entirely on forest ecosystem services such as food, water, building materials, non-timber forest products and less tangible ones, often classified as cultural services, such as a sense of place and cultural identity.

Skills

The indigenous people possess several skills related to the use of their surrounding environment. They use wood species from the forest for the construction of *houses and camps*, *furniture and household utensils*, *boat construction* (canoes and paddles) and for *firewood*. *Fibers and twining materials* are also collected for e.g. the making of hammocks. Pottery is made with vegetal additives.

Calabash and gourd are used as kitchenware. Cooking oils and fats are extracted from the fruits and warm drinks can be made from palm fruits.

Various plants from the forest are used for traditional medicines and insect repellants. Useful medicinal plants are grown in the proximity of the IP/Maroons' houses, while others are gathered from the forest. The forest also provides collectibles for body care, clothing, adornments and music instruments.

Certain seed species are used as body paints during cultural festivities for ornaments, applied to decorate necklaces, hair tubes and musical instruments.

Hunting is mostly done by shotgun. For fishing, a fishing line and a fishing net are the most common methods. In some cases, a small bow and arrow is used to catch certain fish species underwater. Fruits from various plant families are seasonally collected from the forest for consumption, mainly during hunting and fishing trips.

3.6 Education

There is a significant geographical socio – economy disparities in education in Suriname. Children from the interior perform below the average of Suriname. In the interior, the enrollment rate in primary schools is low (71%) compared to the national average rate of 98%. Enrollment of children in the interior drops sharply after the age of 12, when schooling is no longer mandatory. Enrollment rates in junior and senior secondary school are as low as 49% and 21% nationally, and 17% and 0% in the interior. Children who repeat grades in primary school are less likely to complete secondary school. Boys have lower secondary school enrollment and higher repetition rates than girls.

The interior has a gender parity index of 0.9, which is the opposite trend in the coastal area where the gender parity index is 1.0. More boys are dropping out than girls. The structural causes of the low enrollment in the interior includes poor infrastructure, limited school oversight, long travel time, high prevalence of costly private schools, high migration rate, child labor (helping with family duties), pregnancy and marriage. High repetition rates in school are caused by children having to suddenly switch from their local language into Dutch, the national language. Another factor contributing to low school results is that children have mostly teachers from their village and these are generally less qualified to teach (a total of 34% of the teachers in the interior are not qualified to teach).

Suriname has 336 primary schools (323 of which include pre-primary), 112 junior secondary schools and 30 senior secondary schools. 81 of the primary schools and 6 of the junior secondary schools are located in the interior. There are no senior secondary schools in the interior.

3.7 Health

3.7.1 Conventional Healthcare System

The Ministry of Health's department, the Bureau of Public Health, is responsible for the public health programs including environmental health and sanitation. The Bureau of Public Health coordinates preventive health care, supervises and executes programs that provide information on the distribution of diseases and operates a public health laboratory.

The primary healthcare service delivery in Suriname (Figure 3-3) is provided by two Government-subsidized primary health care NGOs, and a number of private family physicians. The first NGO is the Regional Health Service and is responsible for about 43 Primary Health Care (PHC) clinics in the

coastal area. The second NGO is the Medical Mission (MZ) that provides healthcare through 50 health outposts scattered over the interior.

Medical Mission

MZ provides healthcare to indigenous peoples and maroons and is staffed by trained health care workers who primarily originate from the communities they serve. The trained healthcare workers receive day to day guidance from a pool of physicians and nurses through telephone and internet.

In addition to this, seven physicians circulate on a set schedule through the different clinics in order to oversee general healthcare at the health outposts. MZ offers integrated primary healthcare, laboratory services, dentistry and HIV counseling at each health post. MZ's basic healthcare package also covers specialized services in collaboration with specialist doctors in Paramaribo. Such services are needs-based. Emergency transportation from the interior to a hospital in Paramaribo are also included.

MZ's policy states that at least 70% of its clients who are referred for further services should be diagnosed and treated by a specialist doctor in Paramaribo. However, indigenous and maroon peoples living in the interior have challenges when coming to Paramaribo because of the high transportation costs by air, road or boat. Patients' needs chaperones because of language barriers. Usually these chaperones have to come up with funds for travel, food and lodging in Paramaribo, which is often a challenge and can bring IP/Maroons in financial debt (people then go to the goldfields to earn some quick money).

However, since 2015, MZ has received less subsidies from the Government and this has hindered delivering specialized services to health outposts and providing for emergency transport of patients from the interior to Paramaribo. Since November 2017, primary healthcare of five communities in west-Suriname (Kalebaskreek, Donderskamp, Apoera, Washabo, Tapoeripa) has been delegated to Mungra Medisch Centrum (MMC) the only hospital in the District of Nickerie.

Private Healthcare

There are around 150 private family primary care clinics which are accessible to the indigenous and maroon population residing in the coastal area. Access to secondary care occurs through referrals by primary care physicians. There are 5 hospitals, 4 of which are in the capital Paramaribo and 1 in the urban district of Nickerie at the western border. The only psychiatric hospital is in the capital Paramaribo.

Figure 3-3: Primary healthcare facilities and hospitals in the coastal area and the interior.

3.7.2 Traditional Healthcare System

Scientifically tested traditional medicines can provide a cost-effective alternative to western treatment in the interior of Suriname. Because Government subsidies have been cut back to almost half since 2003, the Medical Mission has been struggling to provide a consistent level of primary healthcare in the interior. Meanwhile, international health organizations have put forth a call for initiatives that promote and integrate traditional health practices into the delivery of primary care services in indigenous communities. Several countries in Central and South America have adopted such programs and potentially, the traditional cures from shamans can replace western treatments and significantly diminish the costs for providing healthcare in Suriname's interior.

Currently, indigenous traditional healing is offered in three traditional clinics in the indigenous villages of Kwamalasamutu, Peleletepu, and Apetina, and two Maroon villages of Gonini Mofo and Boslanti. These clinics complement existing western healthcare facilities, handle certain health problems by applying traditional medicines (Leishmania by the Trio Amerindians, treatment of bone fractures by maroons) in a practical way and provide a facility for transfer of knowledge from the shaman to the apprentices by participative observation.

There is a close collaboration between MZ and the Amazon Conservation Team (ACT). This partnership officially started with a Memorandum of Understanding between both parties in July 1999. Both MZ and ACT have interest in the integration of evidence-based traditional medicine in the conventional health care system. A more beneficial and practical way the people of the interior deal with certain health problems is by applying traditional medicines. For this reason, MZ should promote

studies to find ways to apply or integrate these traditional cures in its services. It is unknown how many conventional health professionals are recognizing the indigenous healing system; however, some research is showing they are interested or involved.

According to Herndon et al. (2009), indigenous treatment for malaria works for a mild chronic form of malaria (Vivax) but not for the severe form (Falciparum), which is considered more refractory to indigenous treatment. To prevent the occurrence of sever malaria (Falciparum), or to treat the mild, chronic form of malaria (Vivax), the indigenous peoples have used the plant-based remedy “Wataki” from the plant species *Geissospermum sericeum* for centuries.

Indigenous treatment to cutaneous leishmaniasis (CL) is also well known. Although Pentamidine (PI) is effective for CL treatment, there is a very low compliance to the treatment of patients from the interior.

In case indigenous people lack access to western healthcare in their direct environment, the overall tendency is to self-medicate. Yet, when both western and traditional systems co-exist, indigenous peoples prefer western healthcare. For example, indigenous patients who contracted CL, often visit the traditional health clinic from the Amazon Conservation Team (ACT). In the ACT clinics the main traditional medicines used is "Sipuinuime"; an ointment compiled from three plant lianas.

3.7.3 Health Statistics

The estimated life expectancy of Suriname’s population is 72.5 years, for male it is 70.1 years and for female 75.1 years. However, these figures aren’t disaggregated by ethnicity or between urban and rural areas. Among the most common diseases responsible for mortality in Suriname, HIV/AIDS is ranked 6, while malaria is absent from this list.

HIV. In 2016, there were 730 new HIV cases in Suriname. With an estimated of 4,900 people living with HIV (PLHIV), the prevalence among adults aged 15–49 (1.4%) was almost three times the Latin American and Caribbean (LAC) average of 0.51%.

Malaria. In 2017, during regular malaria screening, 40 of the new positive cases were from Surinamese people, while 498 were imported. Among the imported cases, 95.6% came from French Guyana, 2.8% from Guyana, 0.8% from Venezuela, 0.6% from Brazil, and 0.2% from Africa.

3.7.4 Access to Healthcare

The Law on National Basic Health Insurance came into effect on 9 October 2014 and obliges all residents to have basic health insurance. The Government supports healthcare in three ways: i) through individual policies with the State’s Healthcare Provider SZF, ii) special support to insurance premiums for individuals younger than 16 years and older than 60 years (through the Ministry of Social Affairs) and iii) subsidies to the Medical Mission who provides healthcare services in the interior of Suriname. The public support covers 76% of the population (primarily Government employees, poor, and near poor peoples). The indigenous peoples are primarily included in this group.

SZF accepts all individuals who apply for health insurance. Patients having SZF insurance can rely on urgent care without having to pay premiums for one year (administered by the Ministry of Social Affairs). This group include 22% of the uninsured population that only seeks healthcare when urgently needed. Indigenous peoples are also included in this group.

Private insurance is delivered to 2% of the population (primarily located in the coastal districts) by three private insurance companies. Like SZF, private companies are required to offer basic health insurance package at Government mandated premiums. In practice, private insurance companies practice risk-based selection, use payment caps and prefer to enroll high income, low-risk individuals. Therefore, private-insured individuals are less sick and need less financial support compared to the SZF-insured individuals. It is unlikely this group includes the relatively poor indigenous peoples.

3.7.5 Communicable Diseases

The Ministry of Health (MoH) focuses on primary health care with an emphasis on prevention and control of the following communicable diseases of interest to indigenous peoples and maroons.

HIV. From December 1, 2017, MoH policy changed for treating patients with HIV infection: first only patients with a CD4 count of 350 or lower were treated and now all patients diagnosed with the disease are treated. Treatment guidelines have been updated and now the MoH is training health care workers for implementation.

HIV testing is available at two voluntary counseling and testing (VCT) sites operated by NGOs. In addition, HIV testing is provided in 11 VCT sites (operated by the MoH), the RGD, MZ, primary care facilities operated by private physicians, hospitals and laboratories. The “MoH” pays for all antiretroviral drugs (ARV) and HIV-related laboratory tests while prevention is largely funded by International donors.

Testing services are promoted through proactive outreach, primarily coordinated by i) community-based organizations (CBOs) and NGOs with support from donor funds, and ii) the MoH for rapid test kits. HIV outreach is troubled by several factors: i) stigma and discrimination against HIV positive patients, ii) lack of continuous supply of test kits. Normally MZ doesn’t proactively reach out to communities in the interior for HIV, except for project-related activities or signature days e.g. World Aids Day. MZ routinely tests HIV among pregnant women and patients with tuberculosis.

HIV treatment can be offered by all physicians. Physicians can prescribe ARVs which are dispensed through five Government pharmacies and several private hospital pharmacies in the coastal region, and MZ for people living in the interior. However, patients identify several challenges with HIV treatment and these are: i) high costs for HIV lab services such as hematology and blood chemistry panels, which aren’t covered by the MoH, ii) physicians lack experience to deal with patients diagnosed with HIV, and iii) physicians are reluctant to treat patients with an SZF insurance because of a delay in receiving reimbursement for services.

HIV-positive patients have difficulty linking them to healthcare and navigate to receive treatment. Also, it is impossible to follow HIV-positive patients at the MZ outposts because there lacks a sufficient patient management system. These patients seem to disappear from the radar mainly due to stigma and discrimination.

According to the latest available data, Maroon and Creole populations test HIV more frequently than any other ethnicity. Maroons conduct HIV testing is related to pregnancy. Maroon and Creole population have higher fertility rate than the other ethnic groups. HIV testing by geographic area shows that all districts except Brokopondo and Paramaribo, are significantly underrepresented ($p<0.001$).

Programs for initiating behavioral change and condom distribution are targeted at key populations and are mainly provided by NGOs, concentrated in Paramaribo and in mining areas in the interior. Two of these target populations are “men who have sex with men” (MSM) and transgenders. Both these groups receive support from two NGOs (Suriname Men United and Foundation He+ HIV) supported by the Global Fund. These organizations face a big challenge how to increase condom use especially among MSM; only half of them report using a condom.

The NGOs “Chances for Life” and “Liefdevolle Handen” (supported by Global Fund) engage in prevention outreach to sex workers. However, these prevention outreach programs are currently in transition. The programs are almost entirely donor funded, with the Government providing only condoms and lubricants. Now the continuity of the program is in jeopardy because of the deep recession Suriname is currently experiencing.

Malaria. Malaria health service are delivered to two target populations: i) service for stable communities of indigenous people and maroons delivered by MZ, and ii) service for communities in artisanal mining areas delivered by a malaria service deliverer (MSD) network.

Stable communities: MZ operates through an effective system of i) prevention, ii) case management, iii) providing behavioral-change communication (BCC), information, education, and communication (IEC), and iv) surveillance to keep malaria out of the stable communities.

Migrant communities: Malaria transmission in these communities stems primarily from artisanal miners who work in high-prevalent malaria areas. These miners either visit their families and simultaneously access services in the stable communities or they travel from the neighboring country Brazil.
The MSD network consist of 24 local individuals from the artisanal mining areas (which will expand to 30 in the coming years) who are trained and supervised by National Malaria Program staff based in Paramaribo. MSD’s speak the local language and Portuguese (for Brazilians) and assist miners to do rapid diagnostic tests, thereby avoiding miners to self-treat with unregulated drugs and provides an effective treatment (ACT). In addition to the tests, MSDs distribute insecticide-treated mosquito nets (LLIN), and partner with active case detection (ACD) campaigns in outbreak areas and in the border regions.

Migrants can also access a clinic in Paramaribo (Tropclinic) which provides integrated health services for malaria and other prioritized infectious diseases such as HIV and Leishmaniasis. Tropclinic is in North Paramaribo near hotels and shops that host and supply miners.

Most migrant communities know about malaria treatment in the TropClinic and are less familiar with the MSDs in the field.

3.7.6 Waste Management

The Ministry of Health has established general guidelines for proper management of medical waste, however they aren’t mandatory.

Paramaribo and surrounding area

In urban areas, such as Paramaribo and other nearby towns, waste is handled according to the protocol "Medical Waste management, How to handle medical waste" which was widely distributed among healthcare professionals and institutions". According to the PAHO, the protocol is derived from the WHO protocol on handling, storage and transportation of healthcare waste[3].
Waste is collected in special packages and then send to an incinerator. However, currently, the country lacks good incinerators which are able to destroy all infectious materials. For example, the incinerator of the Academic Hospital incinerator can't destroy microscopic slides.

Medical waste created by the malaria teams operating from Paramaribo is transported and stored in a specially-assigned container located in the yard of the BOG. Once the storage container becomes full, the malaria program destroys this medical waste with donor funds (e.g. Global Fund and IDB funds) The waste is destroyed in an incinerator operated by the company Oil Mop Environmental Suriname NV.

Interior

Medical Mission. MZ handles waste at its health outposts according to a safety and hygiene protocol. This protocol prescribes how to collect medical waste and how to handle it. The protocol was developed by the Ministry of Health in collaboration with PAHO and the "Engineers without Borders (EWB)". Th protocol describes:

- Medical waste, such as bandages, gloves etc. should be collected in yellow bags which have the inscription "Risk for Infection". After these bags are full, they are burned at the end of the day.
- Sharp infectious materials (needles, object glasses, used ampules etc.) are gathered in yellow needle boxes with a "Biohazard" inscription. The needle boxes are collected in a metal container with the inscription "Risk for Infection" and subsequently transported to the oven.

Every health outpost has an oven to burn the medical waste. However, the ovens aren't able to reach high enough temperatures to destroy all infectious materials. The burn residue is buried in the ground without any specific instructions for fencing.

Malaria Program. Waste produced in the goldmining areas is currently handled with the following WHO-guided instructions: 1) burn waste into a hole in the ground, 2) the hole needs to be fenced. Although the WHO guidelines prescribe to burn medical waste behind a fence, however, in practice, this doesn't occur regularly. Inspection of waste management activities is currently absent.

The malaria program is currently unable to implement this protocol consistently and is therefore seeking for a structural solution to develop and implement a comprehensive waste management plan.

3.7.7 Perception about Healthcare

Stable communities

[3] WHO guidelines on water and sanitation.
http://www.who.int/water_sanitation_health/medicalwaste/061to076.pdf

Indigenous peoples and maroons think that western healthcare is superior to traditional healthcare. In case both systems are available. Indigenous peoples and maroons rely on traditional healthcare practices as a second choice, after they find western healthcare (delivered by MZ) insufficient. The reason for IP and maroons to rely more on western healthcare was suggested by the Church influences in the 1960s. The church had forbidden the use of spiritual practices (facilitated by shamans) and this script was followed by the IP and maroons. Traditional healthcare practices are being performed in secret (and low profile). Such practices have only revived under the influence of outsiders supporting the practice in terms of technical expertise and funds, for example the ACT-supported traditional clinics.

Migrant communities

A recent Knowledge, Attitudes and Practices (KAP) study among goldminers showed that they mostly desire health services in terms of a general clinic, a family physician and a place to conduct lab tests. Nowadays, they seek medical assistance mostly in Paramaribo, French Guyana or in one of the MZ clinics in the interior.

With regard to malaria, goldminers don't see this disease as a threat and therefore is of little concern to them. Because of this low threat, goldminers are generally acquiring less information on where to get tested and treated. Yet, goldminers protect themselves against malaria by sleeping with a bed net to protect themselves against mosquitos.

3.8 Customary and Gender Roles

Women are responsible for providing food and taking care of the children. Thus, healthcare is the responsibility of women in both indigenous and maroon communities. Women usually visit healthcare clinics when children are sick or need care. Men usually visit clinics on their own.

In general, the indigenous and maroon gender system assign women to have:

- Less access to resources, such as materials and capital
- Less mobility to travel
- Less authority positions than men
- Less access to educational resources

Women are heavily dependent on men, although in maroon societies this is less than in indigenous culture. In fact, the majority of women in the interior have less opportunity to travel and search for income generation opportunity than men because men are always chosen above women to participate in outside opportunities.

Important to notice is that there are several roles women play in goldmining: i) spouse of goldminers, ii) sellers of goods either in stores/bars or on their own (including prepared food).

When women are spouses of goldminers, they usually encourage their spouse to engage in goldmining in order to sustain their relatively poor families.

When women are entrepreneurs themselves, to sell goods such as food products, drinks and other necessities. These small retail shops are a way for women to receive income. The women often see retail in goldmining regions as their only opportunity for income generation. However, villagers believe these women are also engaged in prostitution in the mining camps. Therefore, women selling goods

in mining camps are easily labeled as prostitutes by their community. In case a woman becomes sick, she can visit the MZ clinic for testing of HIV, malaria or other diseases.

Health Service Delivery

Malaria Program. Currently, a total of 17 women and 7 men are working as MSD (Malaria Service Delivery staff for the malaria program. Of the 24 workers, four MSD are employed by the Greenheart Timber company (of which two are supervisors). For the future, the Malaria program is planning to continue its services without the 4 employees of Greenheart.

The MSD staff operates from their own surroundings – house, camp, shop – to deliver services to others. Because MSD's deliver services near their own social setting, violent acts against women are deemed as socially unacceptable. Grievances related to gender violence and sexual harassment have not been reported. According to the Malaria program, violence against women is not categorized as a big concern because of the social control at the site.

The Malaria program wants to extend their HIV-testing and guidance services to the goldmining areas of Snesie Kondre and Benzdorp. However, they need additional trained personnel who can conduct the HIV testing and counselling. A collaborative effort between the Malaria program and MZ can help solve this problem because in both locations MZ-health posts are available.

Medical Mission. Currently, MZ employs 167 people in 50 clinics. These clinics provide services with a majority of female staff across all functions. These females can address issues of female patients.

Table 3-3: Number and type of MZ staff

Function	Male	Female	Total
Health assistant	27	94	121
Malaria microscopy	5	15	19
Policlinic aid	4	1	5
Person leading the clinic	41	126	167

Source: MZ, 2018

Access to Healthcare and stigma of HIV/AIDS patients

In indigenous societies, people with HIV can easily become stigmatized. When women have HIV they have to visit local health services MZ or MSDs. Both these health providers have trained HIV counselors. The MSDs of Albina and Paramaribo have HIV counselors on site as well as all 50 MZ clinics in the interior.

All services (including HIV testing) are provided in private patient rooms to ensure the confidentiality of the patients. However, an HIV-infected patient can be identified because he/she has to wait two weeks to collect medicine instead of receiving it immediately at the clinic's medicine corner. The reason is that MZ has to order the medicine from Paramaribo. HIV patients receive medicine in a special package with their name and instructions on it, which is very different from generic medicines normally given to patients. The other villagers may notice this and start to ask questions about the person's disease.

3.9 Representation and Participation

Indigenous peoples and maroons have limited opportunities to participate in the design and implementation of healthcare programs. Currently, MZ had initiated a pilot project to consult with IP and maroons through a consultation platform (CP) in Kambaloa and Stoelmanseiland (maroon peoples), and Powaka (indigenous peoples). These platforms aim to maximize the involvement of communities in the planning and execution of their own healthcare. The CP is a collaboration effort between key figures and stakeholders in the community and health workers from MZ.
CP come into action when signals are received from the communities about a particular health problem. Based on these signals, the CP identifies the health needs and plans to target the problem with specific activities.
MZ plans to install consultation platforms in other MZ health outpost as well, but not before they have carried out an evaluation of the current pilot areas.

3.10 Handling of Grievances

Indigenous communities rely on their own structures and mechanisms to handle the conflicts they face, both internally and with external actors.

Internal conflict
The most important unit in indigenous communities is the family and this is the first place where conflict emerges. Dispute resolution is primarily the responsibility of the family members or families involved. Once they cannot resolve the dispute, the disputants (or their family members) bring it to the traditional leadership, who hears the disputing members in a public meeting. All participating community members can give their opinion and they often do this by having smaller meetings. Yet, the final verdict is taken by the highest leader. When community members are disagreeing with the verdict, they will use subtle ways to show discontent e.g. gossip, use of witchcraft.

The content and relevance of the topic of dispute determines whether the meeting is held within the family, the village, a few villages or at the residency of the highest leader. Disputes are usually about violations to customary law such as about land allocation, human behavior, division of goods and benefits. Traditional leaders take a decision based on consensus to safeguard the peace and promote the wellbeing of the community. The latter is part of the socio-cultural duty of the traditional authority.

With the current growing acculturation of indigenous communities, the traditional leadership has weakened, and this reflects in their current ability to handle conflict. Traditional leaders may use their position for self-enrichment and selectively advancing immediate family members. As a result, the tribal structure comes under tension and the community members (especially youngsters) increasingly lose faith in their leaders, leading to loss of obedience and violation of customary rules.

The inability of traditional authorities to promote cohesion, facilitate engagement and handle conflict is growing. More often, the Government (Ministry of Regional Development) is asked to mediate in internal tribal disputes. Yet, the Government has difficulty being in the mediator role because they have a direct interest in the development of the indigenous communities. Mediation often results in a temporary solution, but the conflict remains unresolved.

External conflict

When an indigenous community is challenges or threatened from the outside, they collectively strategize how to respond. This means that one village or several villages deliberate to find a solution that is focused on long-term survival of the tribe. Indigenous communities have several strategies to defend themselves:

- The community will protect the collectivity and togetherness of the tribe at all costs, even if this means that one of its own members has to be sacrificed (e.g. blamed)
- The community will save face of all community members and put the blame on the outsider.
- The community will categorize the outsider as being incomprehensible of the culture
- The community will use historic incidents and/or international laws to demonstrate they have been discriminated and treated unequally compared to others
- The community will blame differences in language rather than take the blame themselves when in conflict e.g. tribal language versus Dutch or Surinamese
- The community can submit a petition to Government or international court. The latter seems to be the preferred way for IP to protect their rights
- The community may collectively have protest on the streets, either at the site of the project or in the political center (Government offices in Paramaribo).

In both internal and external conflict, violent behavior is usually prevented because it doesn't coincide with civilized communities, a designation that is a very important to the indigenous communities in Suriname. However, increasingly communities are dealing with disputes ending in violent outbursts between their own community members and they rely on the police or military to act. Such disputes are the result of acculturation.

3.11 Infrastructure

Present-day Suriname shows has only a small road network covering mostly the northern part of the country. Suriname's 4,500 km road network includes approximately 1,500 km of primary roads, mostly concentrated in the northern coastal area. The low road density of less than 3 km per 100 square km provides limited access to the interior of the country. There are only a few (paved) primary roads connecting certain parts of the country, but the interior remains accessible only by airplane or by boat. A few secondary (unpaved) roads connect some indigenous settlements, but these roads are more often in a bad condition which makes accessibility for these settlements difficult.

Indigenous peoples can use the following main roads to access primary health services in the coastal area:

- *East-West corridor*: This road connects the northern coastal districts from Marowijne in the East to Nickerie in the West of Suriname. When exiting this road near the settlement of Moengo, a (north-south oriented) bauxite road connects the (Maroon) settlement of Langatibiki in district Marowijne.
- *North-South connection*: The Indira Ghandi road which connects the districts of Wanica, Para, Sipaliwini and the southern tip of Nickerie. This road is currently paved until a few kilometers after the international airport in the district of Para. It remains unpaved to the villages of Apoera and Matapi in the West of Sipaliwini and until the village of Wakai in the south of Nickerie.

Another (north-south oriented) primary road is the Martin Luther King road also known as the "Afobakka road", which connects the districts of Paramaribo, Wanica, Para and Brokopondo. When exiting the Martin Luther King road at the point of Berg & Dal, the road to Atjoni connects the district of Brokopondo with (only a small tip of) Sipaliwini until the village of Pokigron. A bauxite road connects the road of Atjoni to the villages of New Jacobkondre and Oemakondre in Sipaliwini close to the Saramacca River.

Road maintenance remains a key challenge in the country as well as traffic related accidents. Especially in the rainy season, the unpaved roads get impassable and several villages become isolated. Fatalities from road traffic accidents are estimated at 19.6 per 100,000 of population. Another challenge is the increasing number of robberies on the unpaved secondary roads.

Public transportation in the interior region is limited. There are only a few scheduled bus routes between Paramaribo and a small number of villages in Brokopondo (e.g. Atjoni, Kwakoegron). In the district of Marowijne there are scheduled bus routes between Paramaribo and Albina (and Moengo).

The larger southern part of Suriname remains accessible only by boat or airplane. There are three local airlines that provide scheduled and chartered air transport services to a number of approximately 50 airstrips in Suriname (Figure 3-4). They operate with small aircrafts (maximum of 22 passengers) from the smaller airport of Zorg en Hoop in Paramaribo. Travel by air is a costly means of transportation for most indigenous people. Three commercial (only chartered) helicopter services operate from the Zorg and Hoop airport as well. The average costs for helicopter flights are approximately between U$ 700 and U$ 800 per hour.

The main rivers used for reaching the villages in the southern parts of Suriname are the Suriname River, Saramacca River and the Marowijne River. Skilled boatmen operate with open deck motorboats (dugout canoes) carrying passengers and cargo upstream of these rivers even managing through dangerous water rapids.

3.12 Energy

Electricity in Suriname is provided by the state electricity company 'Energie Bedrijven Suriname' (EBS). The electricity network follows the same patterns as the road network: Paramaribo and its surrounding coastal districts and communities between Afobakka and Paramaribo (in Brokopondo and Para) are connected to the national electricity network. Inhabitants of villages in Brokopondo (and Sipaliwini) are exempt from paying for electricity and water. The villages located in the south of Suriname (approximately 130) are supplied by the Ministry of Natural Resources through small diesel-power generators. The village generators are -in theory- supplied by the Government with fuel. Electricity through generators is then only provided for 4 to 6 hours per day, on average.

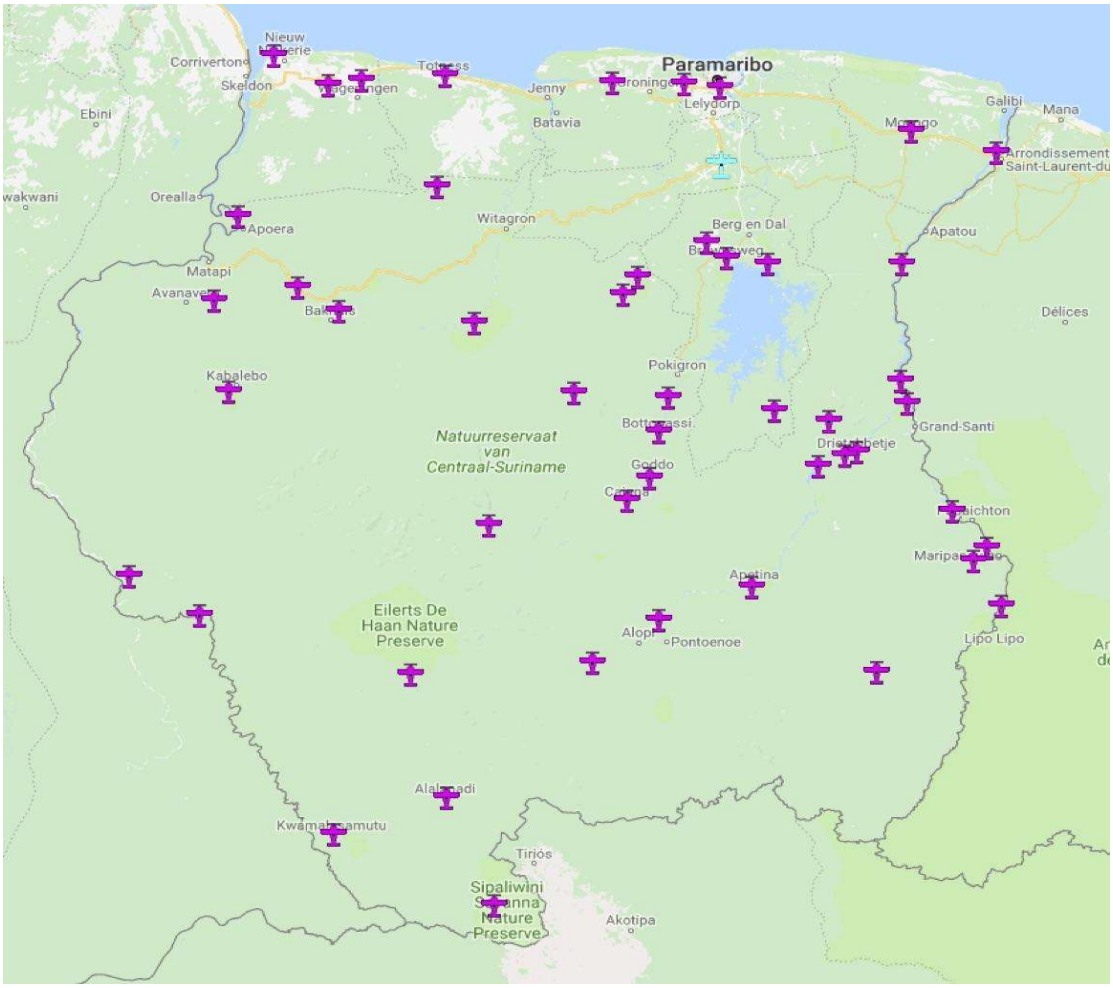

Figure 3-4: Map of main roads and airstrips in Suriname

3.13 Water and Sanitation

Access to water in Suriname is delivered by the state-owned company the 'Surinaamse Waterleiding Maatschappij' (SWM). The northern coastal districts are all connected to the water network system, as well as a small part of Brokopondo. However, only few of the interior villages are connected to this system and thus lack access to safe drinking water piped into their houses. These villages, mostly located in district Sipaliwini and Brokopondo, are predominantly inhabited by IP and maroons.

IP and maroons usually obtain their drinking water from other sources, such a nearby creek or river. Water collection is mainly a women's task. Although local communities perceive the water to be safe for drinking, in some cases both the river and the creek are found to have a high concentration of harmful *Escherichia coli* bacteria, meaning a high risk of catching water-borne diseases. This occurs especially in the dry season, causing increased incidence of diarrhea in these villages.

Another way for IP and maroons to access potable water is to collect rainwater. However, in practice, most villages rely on surface water at least part of the year (dry season) due to seasonal variations and lack of sufficient rainwater storage capacity,

Nearly half of all households in the interior, in particular among Maroon communities, have open defecation systems. In other cases, a toilet also known as a 'privaat' (hole in the ground) is used which is usually located outside the home.

3.14 Telecommunication

Although the access to the telecommunication network in Suriname has improved considerably over the past decade, most of the villages in the interior (especially in Sipaliwini) lack access to a postal service, to national television and radio. Approximately 60% of the population in the interior have cell phone coverage, and in case of a smart phone thus also have access to internet.

4. Social Vulnerability of the Proposed Health Project

4.1 Vulnerability Context

This study uses the sustainable livelihoods framework to analyze the vulnerability context of IP and maroons. These groups consistently shape their livelihood based on social, natural, human, financial and physical capital. Besides these assets, a typical community also can possess supporting structures which are necessary to define the livelihood direction, such as culture, internal rules, social institutions and governance structures. The sustainable livelihood framework has the capacity to picture how a community uses and depends on its specific livelihood assets when they are threatened. Livelihood is a broad concept that encompasses virtually all aspects of daily life. These aspects can be organized in five categories of physical, natural, social, human, and financial capital.

4.1.1 Existing capitals

The following capitals are relevant for IP improved access to healthcare as related to the proposed project:

Social Capital

- *Kinship.* IP have a horizontal system made up of representatives of different kinship groups. This system allows IP leaders to govern with rules based on old traditions and ethics. The system also allows the elders to remain influential in decision-making in their specific groups without having to assume a central role in the tribe.
  In the kinship structure, family members and friends always help each other in time of need and this is the foundation of the tribes' collectivity. Social relations within kinship groups are reinforced by sharing of goods, and this is typical for IP in South America, where kinship is defined by giving rather than biological relations between peoples.
- *Networks:* IP are supported by advocacy groups. The two most vocal organizations are supported by international indigenous rights groups: the Association of Indigenous Village Leaders (VIDS) is supported by international NGOs and the OIS is a member of COICA (Coordinator of the Indigenous Organizations of the Amazon River Basin).

Financial capital

- *Pensions*. Once registered, by paying the monthly pension premium, every citizen can receive a pension from the Government, based on the number of months they paid. This is an important source of income for IP families because jobs in the rural areas and the interior are scarce. These pensions can provide a way of supporting their livelihood.

Natural capital

- *Forest*. By accessing the forest, IP can use their traditional knowledge to collect food, construction materials, medicinal plants to sustain themselves. This system has been instrumental in the survival of IP during the interior war (1986-1992) when healthcare in the interior was interrupted.
- *Minerals*. Maroons engage in extraction activities (gold mining, logging) as a source of income.

Human capital

- *Traditional knowledge*. Each indigenous group has a traditional health knowledge system, some more extensive than others, which allows them to survive in the forest and exist independently

from mainstream society. IP's traditional knowledge consists of a comprehensive body of knowledge and practice that comes from looking at the world as a system of interconnected relationships and is thus directly linked with subsistence livelihood and spiritual beliefs. Indigenous peoples may have only narrow understanding of knowledge types other than traditional knowledge they have gathered through experience.

4.1.2 General Vulnerability of IP and Maroons

Currently, IP and maroons are extremely vulnerable to change because they are transitioning from a nature-dependent group into the western market economy. Although each IP and maroon village has a different development level, the following common vulnerabilities are identified:

Discrimination

The remote living conditions of IP/Maroons makes it very easy for the healthcare project to discriminate against them. Costs for transportation are extremely high due to flights and boats that need to be taken to enter the interior. In rural areas, indigenous and maroon villages are more easily reached by car, in some cases with a short boat trip. Project budgets usually don't allow opportunities for consultations and implementation programs with IP/maroons.
Discrimination of IP/maroons is reinforced by the following characteristics:

- *Limited understanding by others*. Another important point is that IP/maroons and their way of life remain invisible to the general public of Suriname, who is concentrated in Paramaribo. The general public doesn't understand the IP/maroon special rights and many times see them as a nuisance. One reasoning is IP/maroons should behave peacefully and refrain for advocating for their rights, like every other ethnic group (Javanese, Creole, Chinese, East Indian, Lebanese etc.) living in Suriname.
- *Worldview and language difference*. IP and maroons possess a view of the world based on their own knowledge, values and beliefs obtained through their (usually lengthy) journey of existence. The groups usually are in an adaptive mode (Culture of being) rather than working on a plan with set milestones (Culture of doing).
  Worldviews are more traditional with the groups that have relatively less contact with western society - such as the Trio and Wayana in South Suriname. Coastal groups can be considered mostly acquainted with western concepts.
  Each indigenous and maroon group has their own language in Suriname. Understanding western concepts in a traditional language system remains a challenge for IP.
- *Lack of general inclusion laws*. Suriname's law system is founded on the Dutch laws and dates from the 1950s. None of these laws have provisions for participation of IP because the inclusion of IP in laws and regulations started globally in the 1990s. Currently, laws are being revisited and either updated or completely revised. Usually this occurs under pressure from treaties and other binding agreements between the State of Suriname and the international community.
- *Limited political power*. Indigenous people's participation in decision-making structures is generally low. Approximately 22% (11 out of 51) of members in Parliament, the highest law-making body of Suriname, are from indigenous or maroon origin. A larger number of indigenous and maroon peoples are working in the executive branch and the majority is employed by the Ministry of Regional Development. This Ministry's goal is to promote sustainable development with indigenous peoples living in the rural areas and interior.

Internal Barriers

The IP and maroons have very little capital to rely on in case there is a social or environmental calamity. In most cases, decisions are made for them in Paramaribo without considering their input which resulted in unjust treatment. This vulnerable position is reinforced by the following characteristics:

- *Acculturation of tribes*. Tribal structures are fading away with the entry of the market economy (small-scale gold mining, logging e.o.). Indigenous and maroon peoples are increasingly becoming more focused on the self and nowadays collective structures are even used by individual members (especially the traditional leaders) to profit for themselves. Consequently, internal conflicts are on the rise which coincides with weakening of leadership.
- *Small and divided IP population.* Indigenous peoples make up less than 2% of the Suriname population and maroons 12%. Although IP and maroon organizations sympathize with the Latin America indigenous rights movement, they have too small populations to use the force of the mass to advocate for their rights. In addition, the IP and maroon population have divided views about the way to reach the end goal of development. While one group emphasis a zero-sum approach to advocating for indigenous rights (VIDS, VSG), others are more moderate in their approach to find a win-win situation (OIS, ESAV, TRIJANA). The divide in views weakens the IP and maroon movement as a whole. Maroons are generally more organized to work together than indigenous peoples.
- *Relatively high poverty*. In the interior, IP and maroon access to basic human needs - potable water, shelter, income, healthcare and education - is less in than in non-rural areas. Apart from pensions and a few jobs, they have little opportunities to earn a stable income. The UN Human Development Index for this part of Suriname is low; 0.52 compared to 0.70 nationally. This means that the IP have lower changes for: i) a long and healthy life, 2) knowledge generation and 3) a decent standard of living. Therefore, young indigenous peoples increasingly move to Paramaribo to have better education and ultimately find employment. Maroons are generally better off than IP because of their involvement in mineral extraction and logging.
- *Low access to capital*. Suriname is the only country in South America who doesn't recognize collective land rights. Without land, IP and maroons and maroons have difficulty getting a loan from a financial institution. This also means that they have limited means to access emergency funds in case of sickness, especially when they have to travel to Paramaribo. Usually the patient is covered through MZ, but the chaperone needs to pay for travel (when there are no seats available on the patient flight), lodging and food expenses by him/herself.

4.1.3 Vulnerability and Risks related to the Communicable Disease program

The IP and maroons are vulnerable to the following socio-cultural aspects of the project:

- *Discrimination*. Because of the difficulties accessing the interior and the low and discontinued budget of the Government, IP and maroons relatively have lower access to quality healthcare than people from the urban areas.
- *Cultural appropriateness.* The IP and maroons are already used to MZ and its way of working. They prefer to keep and update this system and like to see that health workers can speak the local language. Currently, the Mungra Medical Centre in Nickerie has limited experience with IP/maroons and lacks the infrastructure and tools to effectively implement malaria surveillance and monitoring. As a result, there is a risk that malaria can spread from here to other parts of the interior.
- *Water supply and sanitation.* IP and maroons living in the interior rely on river water or rain water to supply their households. In the dry season, these peoples are susceptible to water-borne diseases that may negatively affect their general healthcare status.
- *Waste management. T*he currently applied protocols of MZ and Malaria program don't follow the WHO guidelines for safe waste management.
- *Stigma and exclusion*. In small societies, stigma usually happens just after the discourse of the tribe announced that someone has been infected with a communicable disease. Such loss of face often leads to suicide because of exclusion from the collective society.
- *Gender and age aspects*. Special provisions are necessary to include elderly and youth in the program and address their specific needs. Elderly are immobile and speak traditional languages, while youth need information and guidance on alcohol and drug use (associated with violence) and sexual behavior.

Based on these vulnerabilities and the existing capitals, the following risks are identified:

- *International human right claim*. Because of this low capacity to exercise national power and weak national laws, IP and maroon organizations may use the international courts to voice their claims. However, the IP and maroons are more focused on other issues (forest, land rights) than healthcare.
- *Discrimination*. Limited efforts to improve the inequality in access to basic healthcare infrastructure and hygiene in the interior (specialized doctor missions, targeted medicine supply, availability of medicines, water supply and sanitation).
- *Cultural inappropriateness of program* excluding sensitivities of language, focus on women, youth and elderly.
- *Stigma and exclusion* of individuals when privacy and psychological support programs for infected patients are absent.
- *Waste management*. Unmonitored/non-compliant storage and disposal of waste in and near indigenous and maroon lands.

4.1.4 Vulnerability and Risks related to the Building Construction

The community, unofficially called Donkerpark, located near the proposed building site of the MoH complex consist of: i) a mix of indigenous peoples and maroons who migrated from different parts of the interior (speaking Saramaccan) and ii) people that have relocated from other urban places in the coastal region (mostly creoles).

Approximately 100 people live in Donkerpark, consisting of families with a huge number of small children. These families are mostly (single parent) female headed households, but there are also families headed or supported by both parents. Depending on their work status, the women, who usually have a formal job, possess either SZF health insurance through their jobs or they have basic SZF insurance. However, not all children have health insurance, even though the mother holds a formal job. The houses/shelters on this terrain are self-made, with some families living in the building that was once a boarding school for girls. After the boarding school had closed its doors, it was illegally occupied by different groups of people. Some of the inhabitants have lived in Donkerpark for more than 20 years. Some of the shelters house 3 or 4 families at once. All shelters currently have access to electricity and to (paid) tap water. There are two water taps located in this area that are managed voluntarily by a few inhabitants. Some inhabitants built their own toilets outside of their shelters, however with questionable drainage. This may pose a problem with regard to hygiene when the terrain floods heavily during the rainy season

The inhabitants of this area are familiar with asbestos and the consequences of inhaling asbestos fumes. They are aware the main building of BOG has a roof made of asbestos. Because they perceive the BOG building to be on a large distance from their home (approximately 400 meters), the people from “Donkerpark” don’t consider themselves at risk, even when the asbestos roof of BOG will be removed. However, the community is willing to receive information about measures to mitigate the potential risk involved.

The Donkerpark community is vulnerable to the following socio-cultural aspects of the project:

- *Lack of land entitlement*. The community has occupied the land, so they lack land entitlement. They can be moved anytime by Government especially if the land is needed for construction purposes. Then, resettlement would become a part of the project, however this is not planned for the present operation
- *Vulnerable population*. With the high number of children is there a risk during construction for traffic safety and when the asbestos roof of the BOG will be dismantled. Children are more susceptible for inhalation of poisonous fumes.
- *Lack of community structure*. The community is a gathering of individuals that have different places of origin. There lacks an outlined leadership structure on which the project can build to have discussions on issues and/or have consultations. Also, internal communication between members of this area is problematic because of the language barrier. The Maroon inhabitants (who speak Saramacca) are less able to understand Dutch or Sranan Tongo. Because of this complexity, parts of the community may become easily discontent and may voice their concerns to local media.

Based on these vulnerabilities and the existing social capitals, the following risks are identified:

- Risk of resettlement of the Donkerpark community at some point in the future, although not provoked by this operation
- Risk of voicing discontent in local media
- Risk of asbestos poisoning to vulnerable children when no adequate measures are taken.

- Risk of traffic safety because of small children running and playing on the streets unsupervised.
- Concerns have also been expressed by the inhabitants about increased flooding risks because of the construction site.

4.2 Impact Assessment

For this study, we classified the risks using a qualitative analysis based on the social baseline assessment and the consultation with the IP/maroon stakeholders. For each potential negative risk, we determined its significance based upon qualitative indicators of the following attributes: i) magnitude, ii) geographical scale, iii) duration, and iv) probability of occurrence.

The significance of the impact is qualitatively ranked with a consequence score based on the criteria below:

- Magnitude: the intensity of the impact
- Scale: the geographical scope of the influence of the impact
- Duration: the time period over which the impact is continuously experienced.

For each of these criteria a score is determined by adding up the individual scores of Scale, Magnitude and Duration from Table 4-1. This now called the consequence score.

Table 4-1: Methodology for ranking identified impacts

Rank	**Score**
Scale: the area to which the effect extends	
None	0
Within the project area; local	1
Outside the borders of the project area; regional	2
Outside the borders of the district; national	3
Magnitude: the intensity of the effect	
None	0
Natural and/or social functions and processes change slightly compared to before; small	1
Natural and/or social functions and processes can be continued in an adjusted form; medium	2
Natural and/or social functions and processes changed drastically compared to before; large	3
Duration: the time during which the effect is felt and its irreversibility	
0 year	0
0 – 1 year; temporary	1
1 – 3 years; short-term	2
More than 3 years; long term or permanent	3

Based on the abovementioned criteria, the identified impact can be valued along six levels as: not significant, very low, low, moderate, high and very high (Table 4-2).

Table 4-2: Value of Impact as Analyzed during the Social Assessment

Consequence score	0-1	2-3	4	5	6-7	8-9
Value	Not significant	Very low	Low	Moderate	High	Very high

After the consequence score, the probability that the impact may occur will be determined using the guidelines in Table 4-3.

Table 4-3: Guideline for estimating the probability an impact may occur

Probability of impacts	
Unlikely	Lower than 40%
Possible	Between 40 – 70%
Probably	Between 70 – 90%
Definitive	Higher dan 90%

The overall significance of the impact is determined by using the measurement of the consequence and probability (Table 4-4).

Table 4-4: The significance valuation

Consequence		**Probability**	**Significance value**	**Description**
Very low	+	Unlikely	**Insignificant**	**The impact is negligible**
Very low	+	Possible	**Very low**	**The impact is very low and has no influence on socio-economic activities**
Very low	+	Probably	**Very low**	
Very low	+	Definitive	**Very low**	
Low	+	Unlikely	**Very ow**	
Low	+	Possible	**Low**	**The impact is low and has no influence on socio-economic activities**
Low	+	Probably	**Low**	
Low	+	Definitive	**Low**	
Moderate	+	Unlikely	**Low**	
Moderate	+	Possible	**Moderate**	**There is an impact on socio-economic activities that may interfere with the decision-making in the project**
Moderate	+	Probably	**Moderate**	
Moderate	+	Definitive	**Moderate**	
High	+	Unlikely	**Moderate**	
High	+	Possible	**High**	**There is an impact on socio-economic activities that interferes with the decision-making in the project**
High	+	Probably	**High**	
High	+	Definitive	**High**	
Very high	+	Unlikely	**High**	
Very high	+	Possible	**Very high**	**There is an impact on socio-economic activities. The project will only be approved under special circumstances.**
Very high	+	Probably	**Very high**	
Very high	+	Definitive	**Very high**	

Mitigation measures will be developed for significance values that are classified as **high** and **very high**. Recommendations for effective monitoring will be made for classifications of negative moderate, low and very low.

Table 4-5: Assessment of Potential Impacts related to the Healthcare project

Risk	Scale	Magnitude	Duration	Value	Probability	Significance of potential impact
Communicable Disease Program						
International human right claims	National/ International (3)	Project continues socially in adjusted form (2)	0-1 year (1)	High	Unlikely	Moderate
Discrimination in access to health program	Local (1)	Social function change slightly (1)	More than 3 years (3)	Moderate	Definitive	Moderate
Cultural appropriateness	Local (1)	Project continues socially in adjusted form (2)	1-3 year (2)	Moderate	Probably	Moderate
Stigma and exclusion of infected IP/maroons	Local (1)	Social function change slightly (1)	More than 3 years (3)	Moderate	Probably	Moderate
Storage and disposal of waste	Environmental//health and safety assessment					
Building Construction						
Resettlement of Donkerpark community	Regional (2)	Drastic change of social functions (3)	1-3 years (2)	High	Unlikely	Moderate
Risk of asbestos poisoning	Environmental//health and safety assessment					
Risk of traffic safety for children						
Risk of flooding						
Risk of grievance in local media	National (3)	None (0)	0 year (0)	Very low	Possible	Very low

5. Socio-Cultural Action plan

This action plan proposes measures to ensure that the IP receive social and economic benefits that are culturally appropriate, including measures to enhance the capacity of the project implementing agencies.

This action plan is based on the legal and socio-cultural vulnerabilities of indigenous peoples and is streamlined with the Operational Policies 765 on indigenous peoples of the IDB, including:

- Identify and target indigenous peoples that could potentially benefit;
- Implement socio-culturally appropriate and effective consultation processes with these peoples;
- Respect the traditional knowledge, cultural heritage, natural assets, social capital, and the systems specific to indigenous peoples with respect to social, economic, linguistic, spiritual and legal systems;
- Adapt services and other activities to facilitate access to them by indigenous beneficiaries, including equitable treatment, and, whenever feasible, adequate procedures and criteria, and programs for capacity-building and compensation of exclusion factors; and (
- Design complementary measures and activities through a process of good faith negotiation with indigenous affected communities.

5.1 Mitigation Measures

The following Table 6-1 presents the impacts on IP and maroons and an action plan of measures to avoid or minimize effects.

Table 6-1: Overview of Potential Measures to Minimize Impacts

Risk	Significance of potential impact	Proposed action/measures	Significance of impact after action/measure
Communicable Disease Program			
International human right claims	Moderate	Open consultation structure for program discussion/co-design/implementation CD program with IP and maroons (see separate consultation plan)	Low Due to constant dialogues, grievances are caught early on and remain at the local level.
		Strategic advice and engagement support on IP/maroon issues for implementation during program life (see separate consultation plan)	
		Implement a grievance redress mechanism related to IP/maroon consultation (see separate consultation plan)	
Discrimination in access to health program	Moderate	Improve basic threats to healthcare such as provision of healthcare personnel and medicines	Low When the new healthcare program considers this by design, it is expected to be implemented within 1-3 years.
		Improve water/sanitation situation in coordination with other Government agencies and NGOs	
		Mainstream program into healthcare system so it is acceptable and user-friendly to IP and maroons	
		Develop specific programs for indigenous women, elderly and youth	
		Funded chaperone support program for patients from interior who have to go to seek emergency healthcare in Paramaribo	
Cultural appropriateness	Moderate	Training for healthcare implementors (malaria program staff, MZ) on IP rights and cultural sensitivity	Low When the new healthcare program considers this by design, it is expected to be implemented within 1 year.
		Outreach programs for IP and maroons in local language	
		Include IP and maroons in delivery of programs (jobs)	

Risk	Significance of potential impact	Proposed action/measures	Significance of impact after action/measure
Communicable Disease Program			
Stigma and exclusion of infected IP/maroons	Moderate	Psychological support program for IP and maroons	Low When measures to support infected patients are taken, it is expected to have affect for less than a year.
		Measures for maintaining confidentiality at the field clinics/facilities	
Storage and disposal of waste	N/A	New proposal development for waste management and implementation	N/A
		Waste monitoring/compliance unit	
		FPIC process implementation waste development proposal	
Building Construction			
Resettlement of Donkerpark community	Moderate	Develop adequate building plan to prevent resettlement	Moderate
Risk of asbestos poisoning	N/A	Environmental/health and safety mitigation measures (see ESIA)	N/A
Risk of traffic safety for children	N/A		N/A
Risk of flooding	N/A		N/A
Risk of grievance in local media	Very low	Establish open consultation structure with Donkerpark community/grievance redress mechanism	Very low

5.2 Recommendations

Indigenous peoples have a special status globally because they belong to the most vulnerable socio-culturally populations. The rights of indigenous peoples should be included in the health programs, even if this has traditionally hasn't been practiced in Suriname. This includes 1) participation of indigenous peoples in the design of health programs, and 2) inclusion of benefits (jobs) from instating new healthcare services. Special attention should be given to these matters in the design of the new program.

There is structural inequality between the healthcare services delivered in the interior compared to the coastal region in terms of 1) types/amount of services available, 2) access to emergency care and 3) access to specialized healthcare. This inequality should be diminished as much as possible when designing a new program for communicable diseases. If not, the program in itself will be good but it is founded on a weak foundation. In the end, the output of the program will be also less than expected.

MZ has 20+ year experience with designing and delivering care programs for IP and maroons. This organization is trusted by the communities and this is an important asset in providing healthcare. The new healthcare program should rely on this experience and knowledge, and preferably work through its network of clinics and healthcare providers.

The general experience is to exclude traditional healthcare and make a sharp distinction between traditional and western care. However, in the case of forest-dependent IP/maroons there might be an opportunity to bridge between traditional and western healthcare methods, especially with the leishmaniasis treatment in programs implemented by IP/maroons together with Amazon Conservation Team.

With regard to hazardous waste, international regulations signed by Suriname (UNDRIP) prescribe a Free Prior Informed Consent (FPIC) Process before storing and managing waste on indigenous territories. Although the GOS hasn't recognized indigenous land rights, it is important to consider that the IP/maroons inhabited the lands and thus are vulnerable populations in the vicinity of the project. It is advisable to undergo a FPIC process with the IP/Maroons for waste management.

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CONSULTATION PLAN FOR INDIGENOUS PEOPLES

IMPROVING THE HEALTHCARE SYSTEM OF SURINAME

Final Consultation Report

4 July 2018

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Preamble

This consultation plan is part of a Socio-Cultural Analysis for a loan sought by the Ministry of Health (MoH) of Suriname to be financed by Inter-American Development Bank (IDB) for the purposes of improving the functioning of the health system in the country and addressing more effectively communicable diseases, non-communicable diseases, and health disparities in vulnerable populations, and strengthening the functioning of the Ministry of Health.

1. Identification and Analysis of Stakeholders

Indigenous and Maroon organizations active in the interior were contacted to inform about their concerns or comments on the expansion of healthcare in the interior (specifically in more difficult to access areas).

The following IP and maroon stakeholders are important to consider ensuring socio-cultural appropriateness of the proposed project (Table 1-1). The team consulted with different types of stakeholders from the organizations mentioned in Table 1-1 including women, men, elderly and youth. Two organizations were repeatedly contacted for sharing their opinion/interest but at the time this report was compiled, were unable to provide input. These organizations were the Association of Village Leaders in Suriname (VIDS) and the Ministry of Regional Development (RO).

Table 1-1: Identified stakeholders input for the proposed project

Stakeholder	Interest	Potential concerns with healthcare and the project
Organization of Indigenous peoples in Suriname (OIS)	-Support social and economic activities of IP -Respect rights of IP	-Concerns about the HIV testing and awareness in Indigenous parts of the interior. Indigenous people are less open to awareness and education about sexual behavior. This is particularly true for adults and elderly. Caution should be taken when handling this topic, and a possible solution is to involve the younger indigenous generation to help with the testing, awareness and education on HIV. -Another concern is about the intake of malaria medication. This medication intake is perceived as an awful and painful process because the pills are large and difficult to swallow. This discourages infected persons to use the medication, and instead they seek alternative medication (such as traditional medicine). A possible solution may be to alter the size of the malaria pills, to a smaller size such as that of paracetamol. -Regarding **women and elderly**, the general concerns of the OIS is the language barrier. Most of the elderly are not used to other languages than their own, so may be reluctant to participate when not communicated with in their own language. Elderly are also not very open to education/awareness on sexual behavior. The same goes for traditional **youth**, but for youth that are in school/and thus (western) educated this is less of a problem. It is important to keep in mind that young children are dependent upon their parents for permission on everything. In general, the need for communication in the communities' languages is stressed by the OIS.

Stakeholder	Interest	Potential concerns with healthcare and the project
Medical Mission (MZ)	- Quality public healthcare in the interior of Suriname	-The MZ provides the primary healthcare for the interior of Suriname, and thus possesses: the infrastructure; trained healthcare personnel that speak the local languages; good quality medicines; years of experience in the field; and are trusted by members of the communities. The MZ covers the more stable villages. Because of a lack of funding and difficulties regarding accessibility and safety of the gold mining fields, the MZ is not able to provide healthcare in these areas. According to the MZ expansion of healthcare in these areas (specifically the gold mining fields in the vicinity of stable villages that are already covered by MZ clinics) should fall under the umbrella of the MZ because of their position of primary healthcare providers. -Another concern is the recent development of former MZ clinics (in the Western Indigenous villages) being taken over by other organizations. This means that the MZ no longer has a grip on handling medical information from these clinics such as malaria incidents, nor can they monitor proper use of medication. If not monitored closely, a malaria outbreak may easily occur. -With regard to HIV the following concerns were expressed: sufficient stocks of condom should be available for all clinics at any time. Health personnel should be trained to raise awareness for encouragement of the use of AIDS medication when tested HIV positive. - The general concern of the MZ regarding **youth** in the proposed project should cover mental health issues such as the alarming and increased drug-use (therefore also abuse). Further study in this field is required to get a better understanding of this behavior, perhaps it could be speculated that the increased use has to with a lack of hope for a better future. - Regarding the **elderly**, the concern is the lack of organized home-care in the interior. The general concern about **women** is that the family planning policy has not yet been effectively put in place by health organizations.
Amazon Conservation Team (ACT)	-Support social and economic activities of IP	ACT has the following concerns regarding the project in general: -it should be considered the amount of metals in the waters from gold mining activities, which have proven to have effects on the fetus and -with regard to the NCD's the following must be considered: the consumption pattern in the communities in south Suriname have changed dramatically over the years, increasing the risk of certain diseases such as diabetes. The consumption of kasiri (alcohol) in the communities by youth, adults and elderly is a normal activity, but also a concern when violent behavior is the outcome. -the biggest concern is the lack of a thorough in-depth study on the socio-economic and cultural challenges that the Indigenous peoples are facing in their area, but more those that live in Paramaribo. The alarming numbers of suicide among Trio and Wayana are a big concern for the ACT. This topic must be treated with care and sensitivity. The ACT has already expressed this specific concern to the Baptist community, the VIDS (Association of Village Leaders) and NIKOS (NGO Institute for Training and Research in Suriname). The general thoughts on the proposed project (from ACT): ACT pleads for a traditional approach to healthcare, rather than the conventional approach (referring to policy- healthcare 'beleid- Gezondheidszorg'). In our experience, traditional healers have had better results with the traditional healing of Leishmaniasis. We propose an inclusion of traditional healthcare systems also to push further study on traditional knowledge (including the Ministry of Health/ Cabinet of the Vice President).

Stakeholder	Interest	Potential concerns with healthcare and the project
Inheems platform ESAV	-Support social and economic activities of IP - Promote education of IP	-Health trainees and trainers/other personnel working in the field should speak the local language(s) or have a translator for good communication with community members -Transparency and clear explanation of the proposed program to the communities -Good relations and understanding with the captains from the communities, which is important for sustainability and continuity of the program -Health workers should receive a salary for their duties, this will motivate them and also provides an income for the communities -A current pressing issue is the number of communities situated at the Marowijne and Lawa River, for activities related to gold mining in the area which contaminates the waters. An increasing number of people feel ill, and they expressed their need for research of the waters and fish.
Association of Saramacca leaders (VSG) VSG will become maroon platform KAMPOS	-Rights-based and cultural sensitive approach in process -Capacity building of maroons for effective participation and ownership	-Concerns with regard to mobile testing possibilities of HIV. Community members or small-scale gold miners may have two reactions when tested as HIV positive: 1.they may feel suicidal or 2.they may feel like they will die anyway so they might as well infect others as well. These reactions may have a great impact on society. That is why counseling and psychosocial support is of utter importance for these patients. HIV testing should not be detached from existing medical infrastructure such as the MZ, and/or it would be better to put local clinics for HIV testing on central spots (such as mooring places) where gold miners frequently pass through. This concern does not include testing for other diseases such as malaria, because of the high survival rate. - The concerns regarding the **elderly** are that they sometimes lack the transport to reach the clinic when they are partly or completely disabled. They also lack a specialized home-care. Regarding the **women**, a careful distinction in approach must be made between dealing with sex-workers in the gold mining fields that may have higher risk for certain diseases, and women of communities itself. Sex workers, especially when not from the area where they work, often have a lower chance of a safety net when diagnosed with HIV/AIDS. This particular issue must be handled with care and consideration.
Trio and Wayana organization TRIJANA	-Support social and economic activities of IP -Respect rights of IP	-Indigenous communities (mainly in the south and east region) are familiar (and are used to working) with health organizations such as the MZ and the PAHO. Other health related organizations may be unfamiliar to them, so to reduce reluctancy for cooperation and support from the communities a clear introduction and explanation of the organizations and proposed programs is necessary. Preferably in the communities' local language.

The valuable comments and concerns of stakeholders about the healthcare program can be grouped in the following categories:

Socio-cultural:

- Health trainees and trainers/other personnel working in the field should speak the local language(s) or have a translator for good communication with community members. Especially elderly have to be approached in traditional languages because few of them speak Dutch or Sranang Tongo.
- Use caution and sensitivity to people's reactions and treatment of HIV: counseling and psychosocial support is of utter importance for these patients.
- Indigenous communities (mainly in the south and east region) are accustomed to longstanding healthcare facilities in their area, thus issues such as reluctance for cooperation with; or making use of new health-related organizations (under an unfamiliar name).
- Indigenous people are less open to awareness and education about sexual behavior, especially the elderly. Caution should be taken when handling this topic. A possible solution is to involve the younger indigenous generation to help with the testing, awareness and education on HIV.
- Mental health issues should be included, especially those cases associated with the increasing drug use among youth.
- Family planning focused on women should be part of the current healthcare services.
- Elderly have limited mobility, so transportation should be provided to bring them to health posts or services should be rendered at home.
- The communities have been changing in terms of eating patterns (more dependency on western food), living (more contact with towns). Especially IP/maroons living in Paramaribo need special attention because of high suicide rates.
- Special attention to sex-workers in the gold mining fields who may have higher risk for certain diseases When they are not from the area where they work, they often have a lower chance of a safety net when diagnosed with HIV/AIDS. This particular issue must be handled with care and consideration.

Organizational:

- Provide transparency about the proposed healthcare program to community members.
- Proposed project should maintain good relations and understanding with the captains from the communities, which is important for sustainability and continuity of the program.
- Expansion of healthcare in certain areas (specifically the gold mining fields in the vicinity of stable villages that are already covered by MZ clinics) could fall under the umbrella of the MZ because of their longstanding position and expertise on primary healthcare providers.
- Proper and careful handling of medical information (such as malaria incidents) from all clinics as well as monitoring proper use of medication is a prerequisite in preventing malaria outbreaks.
- Have sufficient stocks of condoms available for all clinics at any time.
- Health personnel should be trained professionally to encourage the use of AIDS medication when tested HIV positive.
- HIV testing should not be detached from existing medical infrastructure such as the MZ, and/or it would be better to put local clinics for HIV testing on central spots (such as mooring places) where gold miners frequently pass through.

Economic:

- Health workers in the communities (such as MSD's) should receive a salary for their duties; this will motivate them and also provides an income for the communities.

2. Engagement of Indigenous Peoples and Maroons

Objective

The overall objective of engagement of indigenous peoples and maroons in the proposed project is to ensure acceptable[1] and effective[2] inclusion of groups that have a stake, interest or right in the healthcare and those that will be affected positively or negatively by the healthcare project. The main purpose of this plan is to present a strategy for engagement of indigenous peoples and maroons in the proposed healthcare project.

Besides this overall goal, there are several secondary objectives discussed below:

1. Transparency. When indigenous peoples know what is expected of them in each activity, they will have more trust in the project (legitimacy). Since the project is still in a pre-design phase, it is important to provide adequate information and catch grievance at each phase of the project.
2. Capacity building. Stakeholder engagement should build capacity to ensure that the indigenous peoples can participate, particularly for vulnerable groups such as youth, women and elders.
3. Accountability. Engage IP through all phases of the project to improve ownership and accountability of these stakeholders about the project.
4. Free and Prior Informed Consent. Obtain FPIC for the project by actively engaging indigenous peoples in projects' design and operations.

The engagement of IP will have two different scopes dependent on the project component:

- For Component 1 (Construction of a new building), the focus will be on the community living 400m from the proposed construction site at BOG.
- For Component 3 (Improved programs for communicable diseases), the focus will be on all indigenous peoples and Brazilian migrants working in the Gold mining areas and transborder regions, as well as those who live in Paramaribo.

3. Design of Stakeholder Engagement: Principles and Approach

3.1 Principles

A well-designed stakeholder engagement plan adheres to several principles. These principles derive from relevant international laws and standards, IDB Operational Policy on Indigenous

[1] Acceptable inclusion: stakeholders agree with the process and method for stakeholder engagement.

[2] Effective inclusion: stakeholders understand the proposed project and can give specific valuable and timely input according to a defined role.

Peoples (OP-765) and the current situation with regard to indigenous peoples in Suriname. The principles are discussed below.

Principle 1: Respect for cultural characteristics of tribal groups
Suriname's has ten tribal groups with different cultural characteristics. Each group has a particular kinship structures which results in some specific form of decision-making. The proposed healthcare project respects this tribal structure and their decision-making processes, which includes: i) the representation chosen for participating in the proposed project, ii) the time necessary for making decisions and iii) the process by which decisions are made.

Principle 2: Consider the divide in development between coast and interior
The coastal zone (30 km wide strip along Atlantic Ocean) has received all attention since Suriname was a colony in the 1600s. The other part of the country, called interior, was historically designated as a place to harbor runaway slaves and also to keep indigenous peoples, who originally lived in the interior forests. As a result, the coast is much more developed than the interior in terms of infrastructure, industry and Government services.

Principle 3: Consider the reachability of tribal groups
Indigenous peoples and maroons usually live in or nearby forests, and they adhere to a semi-nomadic lifestyle which makes them move more frequently than other groups in Suriname. The proposed project should make an extra effort to keep contact with them, even if they have changed location. The project will not discriminate in including indigenous peoples and maroons because it is generally more difficult to reach them.

Principle 4: Consider age and gender aspects
Implementing the healthcare project will affect men and women differently, especially because they have different customary roles in the traditional lifestyle setting. It will also affect youth and elders differently because they have different ideas about development in general. The project will consider differences in participation as related to: i) the needs of men/women from different ages, ii) role they want to play related to healthcare access, and iii) labor division and position in society.

Principles 5: Recognize the rights and knowledge of tribal groups
The project shall adhere to the tribal peoples' fundamental user rights to participate, access to healthcare and self-determination. The project will recognize this IP/maroon's special lifestyle including the traditional knowledge which has been accumulated over generations.

Principle 6: Create a mutual learning process
The proposed project has to design and develop in ways that will work in the Suriname context. Listening to and learning from each other will be key in the project. Mutual learning will stimulate a process with continuous evaluation and feedback and this will be inserted back into the process. Only then it is possible to have a sustainable healthcare program.

Principle 7: Ensure transparency and effective communication of outcomes

The overall project should be clear to all IP/Maroon stakeholders. Stakeholders will have to be aware about the type of process they are engaging in, what for role they can play and what is expected from them in the role they play (ante). After they figured this out and are actively engaged, the stakeholders should be kept informed about all process outcomes (post). This means not only the one component in which the stakeholder engages in e.g., but also all other components of the project.

Principle 8: Build on existing systems
The project should build on existing structures for engagement of IP/maroons. There are numerous interactions between IP, and also dialogues and working groups that can inform, facilitate discussions and input from stakeholders. These groups should be identified and will be used strategically for promoting IP engagement.

Principle 9: Provide an opportunity for grievance and feedback redress
The project will create an opportunity for grievance and redress that is easily accessible for IP/maroons, so they can voice their problems.

3.2 Approach

Participation level

The starting point of the engagement effort is the pre-design phase of the proposed healthcare project. Engagement of IP/maroons will occur through all the phases of the project - pre-design, design, construction, operation - until the project is fully operational.

Indigenous peoples will be engaged on three levels (Figure 1-1).

The first level is *information sharing* and enables stakeholders to get acquainted with the project and stay informed about the different components of the healthcare project. This action implies one-way information transfer: from the project to the indigenous peoples and maroons. The IP/maroons have the opportunity to engage in an early dialogue about the project, as they are asking questions to process information and conduct their own risk-assessment.

The second level includes *consultation,* and this means that the PIU offers one or more options and listens to the feedback given by the indigenous peoples and maroons. This action implies two-way information transfer: the project will offer options and listens to the feedback given on these options by the indigenous peoples.

The third level includes *dialogue,* and this includes indigenous peoples and maroons being in a continuous dialogue with the project. During this phase, the project informs the IP/maroons about the project progress and opens way for indigenous peoples to engage through dialogues. In case dialogues collapse, the IP/maroons can submit a grievance through the grievance redress mechanism.

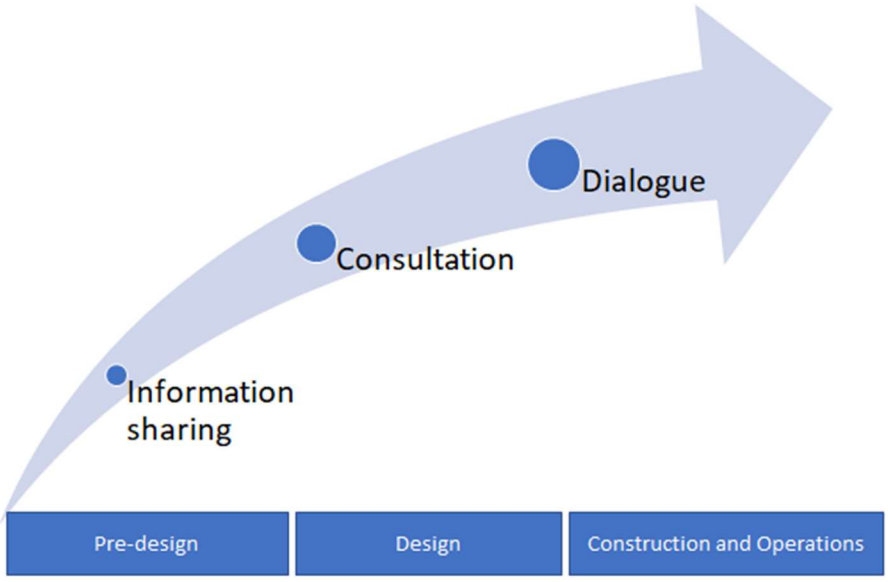

Figure 1-1: Engagement process for IP in healthcare project

IP Facilitators and multipliers

Multipliers and facilitators are important tools to reach IP/maroons. Multipliers are organizations/individuals who can vertically disseminate information fast and effectively to their constituents. Facilitators are organizations/individuals who can mobilize their members to engage in project activities.

We identify the following multipliers and facilitators to support the IP/maroon engagement: i) Association of Village Leaders (VIDS), ii) Organization of Indigenous Peoples in Suriname (OIS), iii) Indigenous platform (ESAV), iv) Association of Maroon Peoples (KAMPOS), v) Trio and Wayana indigenous organization (TRIJANA), vi) Association of Saramacca Leaders (VSG), and the vii) Medical Mission (MZ) clinic in the interior.

We assume facilitators and multipliers will promote IP/maroon rights and safeguards the engagement principles.

4. Engagement Activities

4.1 Information Sharing

Information sharing is the starting point of the stakeholder engagement effort. It aims at giving information without soliciting views or other input from stakeholders. This one-way process

intends to introduce a specific topic (component) of the project, so the stakeholders can get background information on the proposed activities.
The following activities are proposed to share information with indigenous peoples.

Information Meetings
The IP/maroons should be informed about the different components of the project in on-site meetings. The goal is to have IP/maroons get the basic information about the project and how project activities connect with each other, how it may positively or negatively affect the IP/maroons and what benefits they may have from the project. We envisage the following information meetings in the pre-design phase:

- For the building site (Component 1), we propose a public meeting on site with the community members. Specific focus should be set on women to ensure uptake of information.
- For the CD program (component 3), we propose on-site meetings to inform IP about the program. Although the easiest solution is to bring indigenous peoples to meetings in Paramaribo, it is not common practice. Lessons from other development projects - REDD+, Kabalebo and Tapajai hydropower project, oil exploration - teach us that IP/Maroons would like to earn the respect to be visited by the project and prefer a meeting according their own customs of IP/Maroons. Therefore, it is important to have these meetings to comply with the OP-765 as well as the UNDRIP provisions.

Media Campaigns
Media campaigns to inform IP about the CD program (Component 3).
For this program, we propose to inform IP/Maroons by local radio programs and pamphlets delivered through MZ clinics and Malaria program delivery sites. Pamphlets should be translated in the local languages as much as possible (Surinamese and preferably indigenous languages) and it has to be accustomed to the IP's visual representation of concepts. Practice teaches us that when messages are translated into local concepts, IP may better recognize and understand the concepts.

4.2 Consultation

Consultation meetings
During consultation, the IP will provide their feedback on the design plans in consultation meetings. The consultation meetings will follow the same format as the information meetings in the pre-design phase with the exception that the content is different. The content of this meeting is to present i) the results of the ESIA and ESMP (risks and related mitigation plans) of the building construction and ii) opportunities for IP/Maroons to have better access to healthcare and support the development and operation of the healthcare program.
The feedback given will be registered, categorized (component), and considered for the design phase.
Specific meetings should be held for women to address specific problems concerning provision of healthcare for the family.

4.3 Dialogue

Open dialogue with support of IP facilitators and multipliers

In the construction and operational phases, the IP will remain in an open dialogue with the project. The Project Management Unit (PM) should keep frequent contact - every 2 weeks- with the facilitators of IP/Maroons to maintain good relations and capture any problems that may elicit. This will be used for both component 1 and 3.

Specific meetings should be held for women to address specific problems concerning provision of healthcare for the family.

Social media

Now that a significant part of the interior has been provided with telecommunication, social media has become a promising medium to keep stakeholders up to date on all activities that are going on with the project. To reach IP it is important to keep messages simple: focus on announcements, reporting of activities and highlighting interesting developments. Social media will be used for both component 1 and 3.

An overview of all engagement activities is shown in Table 1-2.

Table 1-2: Engagement activities for the healthcare project

Project component	**Target group**	**Delivery method**	**Content**	**Purpose**	**Timing**	**Responsible entity**
Information sharing						
Component 1 Building construction	Community near BOG	Information meeting	General information about proposed project	Inform IP about plans	Pre-design phase	PIU
Component 3 CD program	Total IP/Maroons population, and near mining sites	Information meetings Local radio, pamphlets	General information about proposed project	Inform IP/Maroons about plans	Pre-design phase	PIU with support of multipliers/facilitators
Project component	**Target group**	**Delivery method**	**Content**	**Purpose**	**Timing**	**Responsible entity**
Consultation						
Component 1 Building construction	Community near BOG	Consultation meeting	ESIA and ESMP	Inform IP/Maroons about risks and	Design phase	PIU

				mitigation		
Component 3 CD program	Total IP/Maroons population, and near mining sites		Access to healthcare, benefits	Inclusion of IP/Maroons and traditional systems	Design phase	PIU with support of multipliers/facilitators
Dialogue						
Component 1 Building construction	Community near BOG	Open dialogue Social media Grievance redress	All topics concerning construction	Keep open communication, build trust	Construction and operational phase	PIU
Component 3 CD program	Total IP/Maroons population, and near mining sites		All topics concerning CD program			PIU with support of multipliers/facilitators

5. Facilitation Model

5.1 Tribal Meeting Facilitation

Facilitation within the tribes is quite a different process than common facilitation. Usually tribal members engage in a meeting, so called *krutu*, in which they employ customary ways to reach decisions. Every group has their own ways, and this is unique to their location and historic development. The project should include the following aspects to be effective and comply with the standards for consultation:

- *Selection of the meeting facilitator:* The facilitator should have the following characteristics: i) understand the worldview and cultural history of the tribe, ii) comprehend the worldview and language of the tribe, iii) preferably worked with the tribe before so there is margin of trust, iv) understand the local situation so concepts/examples can be localized. Preferable the facilitator is from the tribe itself, iv) support horizontal discussion.
- *Selection of participants*: IP participants are selected for invitation and this includes a representative amount of men, women. elders and youth.
- *Meeting time and place*: Meetings should also be scheduled at a time and place which is appropriate for all IP to participate. In case some groups are not participating, separate consultations are necessary to solicit their views on the topic discussed.
- *Announcement*: The meeting should be formally announced in a manner appropriate to the tribal members (usually done by the leaders).
- *Language*: The meetings should be preferably conducted in the local language.
- *Timing*: Collective decision making takes a fair amount of time. The project should give the communities enough time to deliberate issues among all interest groups within the tribe.
- *Meeting report*: The project should compile a meeting report in the local language with the following information: i) list of concerns raised by tribal members to the topic(s) discussed, ii) list of decisions made during the meeting and iii) list of participants, divided by gender and age.

5.2 Participatory Group Approach

The overall approach to facilitation is a *participatory group approach*. The participatory group approach allows that: i) everyone participates, not just a vocal few, ii) people give each other room to think and speak, iii) opposing viewpoints can co-exist, iv) people can accurately represent each other's point of view-even when they don't agree with them.

In the participatory group approach, the facilitator's mission is support everyone, as follows: i) encouraging full participation, ii) promote mutual understanding, iii) foster inclusive solutions and iii) cultivate shared responsibility. The facilitator will focus on moving stakeholders from low commitment to high commitment levels.

The method for facilitation is dependent on what is culturally acceptable by the tribal members. However, tribal facilitators should facilitate without interfering with existing customary practices and include some special elements to comply with international and national guidelines outlined in Chapter 2. These include:

- *Ground rules.* Explain the ground rules of the meeting. Explain the rights of indigenous peoples under FPIC: the right to say no. Explain the way agreement will be reached (customary modes of decision-making and consensus-seeking).
- *Present overview*: The facilitator presents the overview of readiness and explains all components and their contribution. In this way, stakeholders will understand what their contribution is to the whole readiness project before they start working into their specific part of the project.
- *Information sharing*. Share information on the proposed project. This includes a general discussion of the idea, after which the community identifies the priorities for their own development. This phase ends with a discussion about the content and execution of the proposed project.
- *Identify customary practices and needs*. Collaboratively identify customary practices and codes that should be considered at project formulation and implementation. Solicit and document needs, as well as associated risks and possible modification to remediate or eliminate potential risks.
- *Decision-making.* Consider enough time for the community to assess risks, threats and opportunities before the start of the project and during execution of the project. Explain the process thoroughly, including the parts where community input is required.
- *Grievance/feedback redress mechanism*: The facilitator informs participants that grievances and feedback about the meeting can be submitted. The facilitator conveys the grievance/feedback redress point of contact, address and telephone number.
- *Outcome reporting*: The facilitator informs participants about how the meeting's report will be shared or disseminated. It should be standard practice to share and discuss the results of meetings and activities.
- *Next steps*: The facilitator explains to participants about the next steps that will be taken in the process, including when and where the next meeting will be held.
- *Meeting evaluation*: The facilitator gathers input from the participants to see if the goals of the meeting were reached.

6. Implementation

6.1 Approaching IP and Maroons

We will follow the guidelines of the VIDS/VSG when implementing the project (Chapter 2 of Socio-cultural analysis), which include contacting the traditional leadership of the village where the engagement should occur.

- *Appointment*. The project should make an appointment for a meeting with the traditional leadership to explain the proposed project details.
- *Agenda*. The project suggests placing certain topics on the agenda. In this context, the traditional leaders can also place corresponding topics on the agenda of the meeting.
- *Participation*. It is imperative to specify what type of participation is required for the IP/maroons in the different phases of the project: formulation, operation and exit. Specific focus should be set on women.

Following this first appointment, we will receive specific guidelines from the IP/Maroons (or their facilitators) to implement the engagement activities outlined in Section 4.3.

6.2 Human Resources

The overall responsibility for the wider stakeholder engagement (including IP and maroons) is the MoH. The MoH will be leading the process through the PIU. Resources necessary for the implementation are: 1) communication expert, and 2) community liaison

Communication Expert

The communication expert should have enough experience with communicating health issues, and should be capable of:

- Internal communication between stakeholders: create simple handouts to give stakeholders an overview of the project.
- External communication with the general public: create media programs and other means to inform the public about the project.

All information for internal communication should be delivered as much as possible in pictorial format with limited text.

Community Liaison

The community liaison should be the focal point for IP/Maroons and has the following tasks:

- Review of all communication materials
- Review and guide work of the meeting facilitators (facilitation plan, agenda).
- Monitor the tribal engagement process (see next section)
- Mediate and resolve incidental disputes and conflicts during project life through the GRM (focal point)

The community engagement expert can also support the MoH with internal trainings about cultural sensitivity, stakeholder engagement and conflict resolution, if needed.

7. Grievance Redress Mechanism

7.1 Goal

The goal of the GRM is to channel grievance into an acceptable, institutionalized mechanism for resolving conflict deriving from project implementation. The GRM mechanism should focus on dialogue and problem solving as an intermediate way for stakeholders to discuss problems.
Besides this overall goal, the GRM has the following secondary objectives:

- The GRM needs to support the project to have better and improved outcomes
- Indigenous peoples can be stimulated to have more voice in the project. The GRM provides an opportunity to these relatively poor peoples, especially in remote locations, to submit complaints and argue for a better health program.
- Indigenous peoples can advocate for their rights. Complaints about violating those rights should be submitted to the GRM and handled accordingly to ensure compliance with international standards.

The GRM will be designed to function at the local level with a countrywide coverage, during the life of the project. The GRM is designed as a quasi-judicial body: a public administrative body which has defined procedures and powers in resembling those in a court of law and is obliged to objectively determine facts and draw conclusions from them as to provide the basis of an official action. The outcome of the GRM is a contractual agreement in which parties have binding obligations.

7.2 Process

From the time the grievance is received until a resolution on the dispute is found (or not), is estimated taking 28 working days.

The grievance, ones received, follows a systematic process consisting of six steps: i) Uptake: receive and registrar the grievance, ii) Research: screen and assess the grievance, iii) Process: proposed resolution approach, iv) Response: formulate and deliver the response, and v) Implement: resolve and monitor the agreement between the project and the complainant (s).

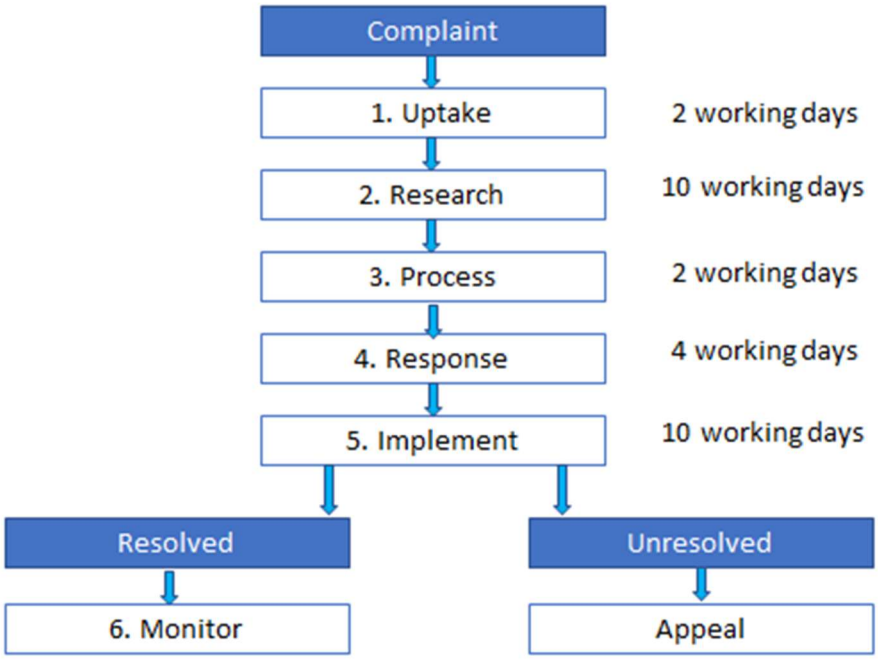

Figure 1-2: Process of grievance handling for the healthcare project

Step 1: Uptake of Grievance

Local forest users are the main clients of the GRM (Table 5). The GRM anticipates reaching these stakeholders in remote locations by offering easy ways to submit grievance face to face or digitally from a distance. Grievances can be submitted through multiple, low cost, channels. Grievances can include written submissions through:

- Face to face interaction with the community liaison focal point at the PIU
- Suggestion/complaint box at the PIU office. This is particularly important for IP who are uncomfortable with face-to face interaction.
- Complaints can be submitted through a designated email address.
- The majority of IP are expected to deliver grievance by telephone because more than 70% communication in the interior occurs with telephones.

Each grievance will be registered by submitting the following information: i) name of the complainant, ii) date of the grievance, iii) nature of the grievance, iv) number of persons involved, v) effect on complainant's activities, vi) type of proof and witnesses.

The PIU contacts the complainant by phone to confirm that the grievance has been officially registered. The complainant is also informed about the process of grievance handling and the administrator conveys the following information: i) acknowledge the receipt of the grievance, ii) overview of the steps in the grievance handling process, iii) the time frame by which a next response is expected from the grievance office, iv) the registration number of the case, v) the contact person for the grievance handling in case there is any more information needed.

The total registration process takes 2 working days.

Role of support groups
An important driver for IP to use the GRM is the availability of a support system. In Suriname, IP have difficulty understanding official formats and often cannot participate in district or national level initiatives due to logistical problems – language and transportation.
We anticipate that indigenous NGOs and interest groups (organizations who also have a role as facilitators in IP engagement), who are already in close contact with IP, act as the support system. This support group consists of individuals/groups who will facilitate in preparing and submitting grievances, such as in: i) writing the complaint, ii) translating the grievance from the local language into Dutch or Surinamese, and iii) bringing the grievance for registration to the PIU office.
The support groups have another important task: disseminating information. They can provide missing information to the local level stakeholders and in this way prevent unnecessary grievances to be submitted.

Step 2: Research: Screen and Assess the Grievance

Screening
When a grievance is registered, the PIU office has to see if it is eligible for the GRM. The grievance is screened for eligibility against several criteria:
- The grievance is related to potential impacts coming from the implementation of the project.
- The grievance mechanism can handle the complaint. The GRM is designed to handle simple disputes in which the focus is on reconciling 1-2 different interests between parties (wants, needs and concerns). The goal is to capture conflicts before they become more complex.

Assessment
The PIU gathers information from the IP complainant, other relevant parties, local resource persons and organizations to gain firsthand information to better understand the problem. The following information is gathered:
- Disputing parties: Who are the disputing parties, their position and underlying interest?
- Importance of issues: What is the main issue and what is the importance (investment in) the issue?
- Sources of power: What sources of power do they have and what do they propose to use?
- Resolution: What type of resolution do they bring forward?

Involvement of the IP complainant in the assessment acknowledges voice, increases mutual understanding of the problem and brings parties closer together.

In case the PIU is party in the dispute, it appoints an independent assessment team (IAT), led by the community liaison officer and two supporters from the local level who are independent experts on the issue. These experts are carefully selected from different entities, such as indigenous communities, Government, interest groups, NGOs, and private sector, as long as they have no stake in the outcome of the dispute.

The total screening and assessment process takes 10 working days.

Step 3: Process: Choose a Resolution Approach

The PIU sets forth a resolution approach based on the outcome of the assessment. A resolution approach is the proposal for a process in which the complainant and other (affected) party come together, mutually discuss the proposed resolution, and mold it into an acceptable process for both parties.

The PIU can choose one of two options for dispute resolution:

Option 1: Self-Problem Solving

The preferable method to use to resolve the dispute is problem solving. The PIU's community liaison officer acts as the mediator to positively influence the interaction process but does not interfere with the decision-making ability of parties.

Option 2: External-Party Problem Solving

In case there are disputes with problems that have been reoccurring or there are discrepancies about facts or data, the case officer decides for intervention of an external mediator. An external party helps parties get involved to sort out difficult issues, improve communication and possibly reach agreement.

Mediation opens doors to parties to collaboratively come up with their own solutions, not specifically for the purpose of "profit", but based on a renewed relationship which is important in the case of IP. The most important part is that mediation does not end up in win-lose situations, where one party wins and the other loses.

Choosing a resolution approach takes 2 working days.

Step 4 Response: Formulate and Deliver

Next, the PIU formulates a written response on the decision and resolution process (*process verbale*). The way the response is formulated is as important as the content of the response e.g. ensuring cultural sensitivity. A response generally consists of: i) the complaint and issues that are taking into consideration in the response, ii) the view of each party about the issues, iii) the rationale for the decision, iv) the decision and approach to resolution. All responses are reviewed and approved by the head of the PIU, as the highest responsible officer for the implementation of the project.

Delivery of the response will be done by the PIU in a face to face meeting with the complainant and any other involved party, preferably at the location where the problem exists. The PIU explains the proposed resolution in a step-by-step process. In case the complainant is not happy with the resolution approach, he/she can appeal or proceed to the Minister of Health. If the complainant is content with the resolution approach, he/she will receive further instructions from the case officer on how to implement the resolution process.

The process for formulating and delivering a response takes 4 working days.

Step 5 Implement: Problem Solve and Conclude

The PIU (option 1) or external mediator (option 2) starts preparing for the resolution process. Preparation includes selecting a strategy, collecting and analyzing background information and designing a mediation plan. After which, the PIU or external mediator conducts the problem-solving meeting with the disputants. Observers and witnesses may be present in these meetings to ensure transparency.

The outcome of a successful problem- solving meeting is a settlement agreement: a contractual agreement between two parties. This contract is in developed in similar fashion as a performance-based contractual agreement: the disputants will sign this agreement and are obliged to comply with its stipulations.

If no acceptable solution is found, the PIU makes an outcome report of the problem-solving session. The report is conveyed to the complainant and all other parties. The complainant can then choose submitting an appeal.

The process of implementing the decision takes 10 working days.

Step 6 Monitor: Track and Inform

The PIU should monitor the settlement agreement, which will have defined, clear and measurable milestones. Each milestone will be documented as part of an internal monitoring system for tracking grievances. The monitoring system can be a simple database from which information can be analyzed to recognize grievance patterns, identify causes of grievance and evaluate how effectively grievances are handled by the PIU.

Complainants and involved parties will periodically be informed by the progress made on the settlement agreement (time frame outlined in the settlement agreement). The PIU uses these in-between contact moments to celebrate accomplishments and motivate the parties. In case parties don’t comply with the agreement, the GoS can interfere through its MoH. If the agreement is properly executed, the case is closed and stored digitally in an archive.

The process of track and inform will take as long as the duration of the settlement agreement (usually between 3-12 months).

8. Monitoring and Evaluation

This section presents a monitoring and evaluation framework for stakeholder engagement.
Three aspects will be monitored during this process:

- Stakeholder participation. Participation will be monitored during each stakeholder meeting.
- Grievance redress. During the process, grievance redress will be tracked.
- Facilitation performance. Each facilitator is subject to evaluation by the stakeholders.

Every sessions will include an evaluation. Evaluations will be done with small questionnaires that will be filled in anonymous.
Monitoring outcomes will be reported to the PIU.

Table 1-3: Indicators for monitoring of engagement

Focus	Indicator	Baseline	Target	Sources of verification	Frequency of data collection
Participation	% of invited participants show up in meetings	Stakeholder identification in consultation plan	>50%	Meeting reports	3 months
	% of active speakers in meetings		>5	Meeting reports	3 months
	% of participants (women) actively engage in program design		>50%	Meeting reports	N/A
Facilitation performance	Score at evaluation form		>85%	Evaluation forms	Every facilitated workshop
Grievance redress	% of registered grievances resolved	0	>90%	Facilitation team	3 months