RAPID ASSESSMENT

# STRENGTHENING INTEGRATED SERVICES FOR INDIGENOUS WOMEN AFFECTED BY HIV AND VIOLENCE

## BOQUERÓN, PARAGUAY

UN VOLUNTEERS

UNAIDS

UN WOMEN

RAPID ASSESSMENT

# STRENGTHENING INTEGRATED SERVICES FOR INDIGENOUS WOMEN AFFECTED BY HIV AND VIOLENCE

## Qualitative Research to Identify the State of the Art on Violence and HIV among Women and Girls in Boquerón, Paraguay

**UN WOMEN**
**Asuncion, Paraguay, 01/10/2016**

UN VOLUNTEERS UNAIDS UN WOMEN

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# LIST OF ACRONYMS AND ABBREVIATIONS

| | |
|---|---|
| ARV | Antiretroviral |
| CDE | Documentation and Studies Center |
| CEDAW | Convention to eliminate all forms of discrimination against women |
| CN | National Constitution |
| CODEHUPY | Coordinator of Human Rights of Paraguay |
| CODENI | Municipal Council for the rights of children and adolescents |
| DGEEC | General Directorate of Statistics, Surveys and Census |
| FEDAVIFA | Federation of Associations for Life and Family |
| FIMI | International Forum of Indigenous Women |
| SWOT | Strengths, Opportunities, Weaknesses and Threats |
| IBS | Basic Health Indicators |
| ITS | Sexually Transmitted Infections |
| MIPY | Articulation of Indigenous Women of Paraguay |
| MSPBS | Ministry of Public Health and Social Welfare |
| MDG | Millennium Development Goals |
| ODS | Sustainable Development Objectives |
| OG | Government Organization |
| ILO | International Labor Organization |
| NGO | Non-Governmental Organization |
| UN | United Nations Organization |
| UNAIDS | Joint United Nations Program on HIV and AIDS |
| PEP | Pre-Exposure Prophylaxis |
| PVV | Person living with HIV |
| SAI | Comprehensive Care Service |
| SSRR | Sexual and Reproductive Health |
| STP | Technical Secretariat of Planning |
| TB | Tuberculosis |
| TM | Mortality Rate |
| USF | Family Health Unit |
| HIV | Human Immunodeficiency Virus |
| UNV | United Nations Volunteers |

# 1. INTRODUCTION

Qualitative research to identify the status of the situation of violence and HIV among women and girls in Boquerón, Paraguay, is part of the Latin America and the Caribbean Regional Project to Strengthen Integrated Services for Indigenous Women Affected by HIV and Violence.

Thus, UN Women, the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the United Nations Volunteers programme (UNV) are working in tandem on the issue of HIV in indigenous peoples and exploring potential areas for more joint work in the countries of Latin America. UNV, which promotes inter-agency programmes with seed funds, has shown interest in a proposal that seeks to reduce violence and vulnerability to HIV among indigenous women in Paraguay and Brazil. The purpose of this consultancy is for the three agencies to understand the situation of violence and HIV among indigenous women and the existent current services in three locations in Boquerón, Paraguay.

Important antecedents to this intersectoral and inter-agency coordination within the United Nations System, with the active and key participation of the indigenous women in question, have been the studies conducted in Ecuador and Guatemala in the previous two years, which analysed the factors that limit indigenous women's access to comprehensive HIV care, including discrimination on grounds of gender, ethnicity and socioeconomic status. In addition, the drivers that motivate indigenous women to demand and use comprehensive HIV services have been identified. This analysis has led to progress on one of the recommendations made by the World Conference on Indigenous Peoples in 2014 with regard to HIV, which encourages and promotes advocacy for States to define strategies to overcome barriers and ensure that services are more effective and consistent with the specificities and sociocultural realities of indigenous peoples, by generating evidence as inputs for advocacy at national, regional and United Nations Cooperation Agency decision maker-levels on the urgency to respond to HIV in a comprehensive and inclusive manner for emergent vulnerable groups.

Taking heed of lessons learned and South-South cooperation, UNV, UNAIDS and UN Women are planning a preliminary diagnosis of the situation of HIV and violence against women in indigenous peoples, and the added value of volunteer work, in three places in Boquerón, Paraguay. A similar study will be conducted in Alto Solimões, Brazil. These two countries were selected because (1) they have gender diagnoses or similar studies; (2) they have prioritized the need to improve data and interventions on HIV/VAW in indigenous peoples; (3) there are UNAIDS and UN Women offices and/or staff in the country. These studies will contribute to strengthening the evidence base for proposals for funding to be submitted to UNV headquarters, and to improve existing services.

This qualitative study will be conducted in three places in Boquerón, Paraguay:

1) Filadelfia -Uj´he Lavos: Nivaclé -A new settlement in the centre of Filadelfia: Ayoreo - Cacique Mayeto: Enlhet Norte

2) Neuland -Cayim O Clim: Nivaclé

3) Loma Plata Yalve Sanga: Nivaclé and Enlhet Norte and Enxet Sur.

# 2. OBJECTIVES OF THE STUDY

**General:** The overall objective is to find out about the situation of violence and HIV among indigenous women and about services available in order to be able to design appropriate interventions in locations in Boquerón, Paraguay.

**Specific: i)** to identify indigenous women's and girls' needs for interventions on HIV and violence; **ii)** to map existing services to holistically address HIV and violence, as well as map municipal and community level organizations working in the field of gender-based violence and/or HIV; **iii)** to identify opportunities and the value added by volunteer and South-South cooperation work, including volunteer networks on the ground that could be key actors.

# 3. REFERENCE FRAMEWORK

## 3.1 Geographical, economic and health context in the Department of Boquerón

The Department of Boquerón is the largest political-administrative division in Paraguay (Chaco), with an area of 91,669 km$^2$ and a population of only 62,784, making it the Department of Peru with the third lowest population density at only 0.8 inhabitants per km$^2$, against a national average of 16.7 inhabitants per km$^2$.

It is the department with the second highest indigenous population (21.2 per cent) and it is the third highest for numbers of indigenous communities (46 communities, representing 9.3 per cent of the total in the country). Of the total of indigenous communities in Boquerón, 41 per cent have no land titles or own land, making it the third ranked department for problems of access to land by indigenous populations (STP/DGEEC, 2012).[1]

This serious problem of access to land is further deepened by the 50 per cent cut to the "lands" section of the National General Budget for 2016, which is where payment is made to indigenous communities for acquisitions of and/or compensation for the purchase or expropriation of real property.[2] With less budget for this policy and less access to land by indigenous people, this perpetuates the situation of forced migration to urban centres, extreme poverty and social inequality that together generate and sustain the scenarios of violence and exclusion described in this report.

### 3.1.1 Poverty

The Department of Boquerón is one of the poorest in Paraguay. The percentage of poor is 23 per cent and extreme poor is 14 per cent. With regard to poverty rate according to language, a gulf is observed between the poor who speak Spanish, at 5.4 per cent and those who speak indigenous languages, where the poverty rate is 54 per cent. (DGEEC, 2015).[3]

Nationally, 63 per cent of indigenous people live in extreme poverty, 93 per cent do not have access to water, 70 per cent have no access to electricity and live in houses with dirt floors, while 41 per cent of five-year-olds suffer from chronic undernutrition. (Tekoha, 2014)[4]

Boquerón, as one of the departments with the greatest poverty and inequality and one of the largest indigenous populations, does not escape this context.

Despite many efforts at political and private levels, the indigenous population of Boquerón and in the rest of the country continues to be among the most vulnerable. Driven by the lack of land and lack of access to the natural resources that have historically been the source of their livelihoods, there is ever more internal migration whereby entire communities are forced to move to urban areas in search of jobs and resources to support their families, or they are obliged to assign or sell their farms to soya bean and livestock companies.[5]

1 Secretaría Técnica de Planificación-Dirección General de Estadísticas y Encuestas y Censo [Technical Planning Secretariat - General Directorate of Statistics, Surveys and Census]. III Censo Nacional de Población y Viviendas para Pueblos Indígenas. Censo Comunitario, 2012 [III National Census of Population and Housing for Indigenous Peoples. Community Census 2012].

2 Ayala, Oscar (2015). Derechos de los Pueblos Indígenas. In: CODEHUPY, 2015. Informe de DDHH en Paraguay. Asunción, Paraguay

3 Dirección de Estadística, Encuesta y Censo. Encuesta Permanente de Hogares [EPH, Permanent Household Survey], 2015.

4 Tekohá/European Union. Sistematización del Primer Encuentro Nacional de Mujeres Indígenas en el Paraguay. Defensoras de la Identidad y de la Vida. [Systematization of the First National Meeting for Indigenous Women in Paraguay. Defenders of Identity and Life] Asunción, 2014

5 Ayala, Oscar (2015). Derechos de los Pueblos Indígenas. In: CODEHUPY, 2015. Informe de DDHH en Paraguay [Report on Human Rights in Paraguay] Asunción, Paraguay

### 3.1.2 Morbidity

The percentage of low birthweight infants is 6.5% higher than for the Chaco region and the country. The Department of Boquerón is the third ranked department for incidence of low birthweight infants.

The tuberculosis (TB) rate is 95.8 cases per 100,000 inhabitants in Boquerón, three times higher than the national rate of 30.5 cases per 100,000 inhabitants. Nationally, Department of Boquerón has the third highest TB rate in the country.

Regarding the incidence of HIV, it is 29.7 new cases per 100,000 inhabitants, much higher than the national or Chaco region rates. Given the very low population density, this rate places Boquerón as the department with the highest incidence of HIV in the country.

### 3.1.3 Mortality

Regarding mortality indicators, Boquerón has some of the highest rates in all the country, particularly for neonatal deaths (24.4, compared to a national rate of 10.6 per thousand inhabitants); infant mortality (29.7 compared to a national rate of 14.6 per thousand live births) and mortality of children aged under 5 years (34.2 compared with a national rate of 17 per thousand live births).

With regard to maternal mortality, Boquerón is ranked fourth in the country with a rate of 152.2, compared to the national rate of 96.3 per 100,000 live births.

Finally, for the rate of mortality due to communicable diseases, Boquerón is in third place nationally with a rate of 34.4, compared to a national rate of 32.3 per 100,000 live births.

### 3.1.4 Resources, services and coverage

According to data on resources, health services and coverage, the Department of Boquerón has: the lowest number of beds in relation to the number of inhabitants, at only 0.4 beds per 1000 inhabitants and the second lowest number of outpatient clinic attendances; for infant and maternal health coverage, it is in fifth highest place for institutional

**TABLE 1**
**Morbidity indicators (Basic Health Indicators-BHI-, 2013)[6]**

| | % of infants with low birthweight | Incidence of TB. Rate per 100,000 inhabitants | Incidence of HIV |
|---|---|---|---|
| National total | 6.1 | 30.5 | 14.6 |
| Western Region | 6.3 | 100.4 | 22.3 |
| Boquerón | 6.5 | 95.8 | 29.7 |
| National rank | 3 | 3 | 1 |

6 Ministerio de Salud Pública y Bienestar Social (MSPBS)/ Dirección General de Información Estratégica en Salud (DIGIES). [Ministry of Public Health and Social Welfare (MSPBS) / General Directorate of Strategic Health Information (DIGIES)] Indicadores Básicos de Salud [Basic Health Indicators]. Paraguay 2015.

TABLE 2

## Mortality indicators (IBS, 2013)[7]

| | General mortality per thousand inhabitants | Neonatal mortality per thousand inhabitants | Infant mortality per thousand live births | Mortality of children aged under five years per thousand live births | Maternal mortality per 100,000 live births | Mortality due to communicable diseases per 100,000 inhabitants |
|---|---|---|---|---|---|---|
| National total | 4.1 | 10.6 | 14.6 | 17 | 96.3 | 32.3 |
| Western Region | 4.3 | 14.8 | 22.3 | 28.3 | 199.8 | 38.4 |
| Boquerón | 4 | 24.4 | 29.7 | 34.2 | 152.2 | 41.4 |
| National rank (out of 18 departments) | | 1 | 1 | 1 | 4 | 3 |

TABLE 3

## Indicators of resources, services and coverage (IBS, 2013)[8]

| | No. of beds per thousand inhabitants (MSPBS) | Outpatient care (all kinds) per inhabitant per year (MSPBS) | % institutional deliveries | % mothers with 4 or more antenatal check-ups |
|---|---|---|---|---|
| National total | 1.1 | 1.5 | 96.2 | 80.6 |
| Western Region | 1.2 | 2 | 91.6 | 71.2 |
| Boquerón | 0.4 | 1 | 94.9 | 72.5 |
| National rank (out of 18 departments) | Lowest in the country | 2nd lowest | 4th lowest | 5th lowest |

deliveries, while 5 per cent of deliveries still take place outside of health services and Boquerón is the fifth lowest department for antenatal check-ups with only seven out of 10 women having four or more check-ups throughout their pregnancy.

These indicators place the Department of Boquerón as one of the regions with the greatest health problems, worsened by abysmal infrastructure and health coverage and by high rates of poverty and exclusion, especially concentrated in indigenous communities.

7 MSPBS/DIGIES (2015) op cit.
8 MSPBS/DIGIES (2015) op cit.

## 3.2 Human rights approach and indigenous peoples[9]

When discussing ethnic discrimination, we are usually referring to the unequal treatment received by certain social groups based on their ethnic or linguistic grouping. This unequal treatment refers to the lack of access and opportunities to access and enjoy all the human rights guaranteed by the international and national legal framework. Foremost among the least respected human rights of indigenous peoples are the rights to land, work, education, health, decent life, and life free from violence, among others.

Indigenous peoples fight for "equal rights", but this must not be confused with "the same rights"[10] as those of the non-indigenous population. The right to live their own culture in their own territory does not imply a need to "integrate" into national society with equal rights to others, but rather respect for their cultural identities by Paraguayan society as a whole.

The cause of discrimination against indigenous peoples is ethnocentrism, a universal phenomenon in every human society, including indigenous peoples. Ethnocentrism means overvaluing one's own culture to the detriment of that of others.

This phenomenon always turns the "others" into a strange, threatening group that must be brought under control by means of a series of symbolic, ideological and institutional mechanisms.

9 Lehner, Beate (2002). Discriminación a los pueblos indígenas. [Discrimination against indigenous peoples] In: Bareiro (comp.). Discriminaciones. Debate teórico paraguayo. [Discriminations. Paraguayan theoretical debate]. UNFPA/CDE.

10 An example of this is the right of indigenous peoples to communal ownership of land, in contrast to the notion of "private property" on the part of non-indigenous people, which is interpreted as a violation of the principle of equality before the law and, furthermore, the right to formal education guaranteed under the Constitution and legislation could well be considered as an imposition on indigenous peoples on account of its content, procedures and ethnocentric approaches, which is rejected by many indigenous peoples (Lehner, Beate, 2002).

# 4. LEGAL ENVIRONMENT

Since the 1980s, Paraguay has had one of the most progressive legal frameworks for indigenous peoples on the continent, such as Law 904/81, the Statute of the Indigenous Communities, which ensures indigenous peoples' access to land, legally recognizes their communities and guarantees respect for their customary law.[11]

According to the National Constitution (NC), in force since 1992, Paraguay recognizes itself as a pluricultural and plurilingual country, whereby legal pathways have opened for the special rights of indigenous peoples to be claimed. Chapter V of the NC recognizes the existence of indigenous peoples as groups that predate the constitution of the Paraguayan State itself. Laws 904/81 and 234/93 together form a legal framework that is highly favourable to and respectful of our diversity.

The Paraguayan legal order includes treaties and international recommendations and standards that commit the Paraguayan State to fulfil the human rights of indigenous peoples, with a significant number of laws and decrees on this matter. Among them is ILO Convention 169 and the United Nations Declaration on the Rights of Indigenous Peoples. Even so, this regulatory framework is broad in its recognition of rights on paper, but effective application is far from real for indigenous peoples and communities.

One important advance is that on 7 September 2015, the Executive promulgated Law 5469/2015 "On the Health of the Indigenous Peoples", through which was created the National Directorate for the Health of the Indigenous Peoples and the National Council of Indigenous Health. This latter body is tasked with ensuring the participation of indigenous people in the public management of health services and has membership of each of the 19 indigenous peoples of Paraguay.

## 4.1 Legal situation in relation to HIV/AIDS and sex education[12]

Fifteen years on from the Millennium Declaration in which 189 countries (including Paraguay) pledged to fulfil the Millennium Development Goals (MDGs), there still remain major gaps in fulfilment of making access universal for prevention, treatment and support for those living with HIV, specifically the MDG relating to combating HIV/AIDS, malaria and other diseases.

Nevertheless, Paraguay has made significant progress, especially in increasing coverage for provision of free screening tests to all health services, a significant increase in access to free treatment for people who need it and updating the legal framework through the promulgation and enabling regulation of Law 3940/2009. [13]

11 The inclusion of the notion of "communities" in law 904/81 and in the Constitution has led to conflicts within indigenous peoples, since they have not had the notion of the concept of "community" in their culture (which is of Protestant and Anglo-Saxon origin), but instead, traditionally organize into clans or large families.

12 Negrete, Martin (2015). Universalizar los DDHH de las Personas que Viven con VIH. Un nuevo desafío para los próximos años. [Making the human rights of those living with HIV universal. A new challenge for the coming years]. In: CODEHUPY, 2015. Informe de DDHH en Paraguay [Report on Human Rights in Paraguay] Asunción, Paraguay.

13 Law 3940 of 14 December 2009. This Act establishes rights, obligations and preventive measures in relation to the effects produced by the Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS). Available at: http://digesto.senado.gov.py/ups/leyes/7946.pdf

Even so, in spite of these advances in Paraguay, as mentioned, there remain major gaps in access to screening and appropriate treatment and, most of all, in access to justice and reparation in cases of violations of the human rights of people living with HIV (PLWH), especially for members of particularly vulnerable groups, specifically in key populations. In line with this, the UNAIDS strategy 2011-2015, aimed at "zero new infections, zero discrimination and zero AIDS-related deaths" warns that there is little chance of achieving the goals of reducing infections and deaths without succeeding in reducing stigma and discrimination, the main barriers to halting and turning the epidemic back (UNAIDS, 2010).

In this regard, the lack of political will to address and pass the draft law "against all forms of discrimination" that a civil society coalition has been promoting for several years is identified as a clear barrier.

Law 3940/2009 and the regulation thereof by resolution SG 675/2014 remains the only law in the national legal framework that explicitly punishes acts of discrimination based on people's HIV status.

Similarly, no significant progress has been identified in 2015 on the promulgation of laws to complement Law 3940 to guarantee the full exercise of human rights of all persons, particularly the most vulnerable.[14] On 31 October 2015 there was a demonstration named "March for Life and Family" organized by organizations around the Federation of Associations for Life and Family (Fedavifa), whose core message has been an open onslaught against United Nations System agencies, especially the World Health Organization (WHO) and the human rights organization Amnesty International, which have been accused of trying to impose a "gay and gender ideology",[15] evidence of a clear rejection of international human rights and health instruments subscribed to by Paraguay.[16]

This demonstration was a response to the recent recommendation of Mr Dainius Pūras, Special Rapporteur of the United Nations Organization (UNO) on everyone's right to enjoy the highest attainable standard of physical and mental health in relation to the need to pass a law against all forms of discrimination, saying that "Paraguay is amongst the few countries in the region which do not have such law and this represents a historical debt to Paraguayan society". In addition, he also recommended implementation of the National Plan for Human Rights Education in schools with emphasis on sex education and warned of the consequences of religious groups interfering in schools, spreading information with no evidence base, thus making it difficult for teenagers to make correct decisions in relation to the exercise of their sexuality, contributing to the increase in teenage pregnancies and the risk of infection by HIV and other STIs (United Nations, 2015).

The years to come are an opportunity for Paraguay to close the gaps identified within the term of the MDG evaluation period and to begin a new era with the new 2030 Agenda.

From 2015, based on the MDGs, United Nations Member States established a 2030 Agenda for Sustainable Development that includes a set of 17 Sustainable Development Goals (SDGs) to end poverty, fight inequality and injustice and take action

14 Between 2004 and 2010 there was debate on a series of draft bills in the Paraguayan Parliament on sexual and reproductive rights and non-discrimination in all its forms. These bills are: (1) Law creating a programme of prevention and assistance for the victims of punishable acts against sexual autonomy and against minors; (2) Sexual, reproductive and maternal perinatal health; (3) Against all forms of discrimination; (4) Guiding pedagogical framework on sex education. None of these initiatives has been approved, largely as a result of pressure from conservative groups through an articulated disinformation campaign.

15 Diario ABC Color (01/11/2015) Available at: http://www.abc.com.py/nacionales/religiosos-contra-la-onu-oms-y-amnistia-internacional-1422589.html (Accessed 11/06/16)

16 Paraguay has ratified every human rights treaty and convention except the Inter-American Convention against Every Form of Discrimination and Intolerance and the Inter-American Convention against Racism, Racial Discrimination and Related Forms of Intolerance.

on climate change. Goal 3, "Health and Well-being", adopts a holistic vision focused on universal health coverage and an iron commitment to end the epidemics of AIDS, TB, malaria and other communicable diseases by 2030.

The new Global Goals and the Agenda 2030 go well beyond the MDGs, addressing the root causes of poverty and inequality.

As a complement to this new global commitment, the UNAIDS Coordinating Board approved a new and ambitious strategy for 2016-2021 with the goal of ending the AIDS epidemic as a threat to public health by 2030, this being one of the first United Nations System strategies to strategically align with the SDGs.

## 4.2 Legal situation with regard to gender equality, including violence against women

Existing policies and laws form part of the favourable context for promoting fair access to services according to the need of women, girls and adolescents. Among the laws passed and services provided in accordance with commitments entered into by Paraguay based on the Beijing Declaration and the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), as follows:

**Law 1/1992:** Partial amendment of the Civil Code

**Law 34/1992:** Creation of the Women's Secretariat of the President of the Republic

**Law 834:** Electoral code (minimum quota of 20 per cent women on candidate lists for elections)

**Law 1160:** Amendment of the Criminal Code (introducing several articles on the protection of women from violence)

**Draft bill on SRHS:** Process driven by civil society. Has not been presented in Parliament

**Law 1600/00:** Against domestic violence

**Law 1863:** Agrarian Statute (Preferential treatment for awarding lots to women heads of households)

**Law 2907/06:** Protecting resources for SRHS and delivery kits, so that funds are not reallocated

**Law 3440/08:** Amendment to the Criminal Code (articles on domestic violence)

**Law 3940/09:** Establishing rights, obligations and preventive measures in relation to the effects of HIV and AIDS.

**Law 4084/2010:** Protection of maternity: Establishment of protections for students who are pregnant and mothers.

**Law 4313/2011:** On ensuring budgets for reproductive health programmes and provision of delivery kits by the Ministry of Public Health and Social Welfare.

**Law 4675:** Raising the Secretariat of Women to Ministerial rank

**Law 4788/2012:** Comprehensive law against trafficking in persons.

According to Mrs. Line Bareiro, member of the United Nations Committee on the Elimination of Discrimination against Women (CEDAW), there still persists in Paraguayan law the concept of "habituality" in relation to domestic violence, according to which for a case of violence in a partner relationship to become criminal there has to be "habituality", that is, the abuse has to be habitual and for it to have occurred once is insufficient. She also recalled that CEDAW had already made a recommendation several times to the Paraguayan State to put an end to the

concept of habituality that prevails in the Paraguayan legal framework.[17]

## 4.3 Situation of violence against indigenous women of Paraguay

The main challenges faced by indigenous peoples in Latin America in general, and in Paraguay in particular, remain their situation of extreme poverty and lack of access to land. This situation has a disproportionate effect on indigenous women and children, who are the main victims of poverty, lack of access to education, health care and justice and to a greater incidence of monolingualism than in men, lesser chance of accessing paid work and mobilization outside the communities which, on top of the patriarchal systems that dominate western culture and many of the indigenous peoples, puts women in a particular scenario of vulnerability: they are women, they are poor and they are indigenous (Sieder and Sierra, 2010).[18] In this case it can be clearly seen how categories of gender, social class and ethnicity intersect to create situations of huge inequality.

In this regard, the International Indigenous Women's Forum (FIMI, from the Spanish, 2006) reported that the physical, psychological and sexual violence suffered by indigenous women is based on their gender, social class, ethnicity and history,[19] further aggravated by the context of structural and institutional violence suffered by indigenous peoples in general.

Some local studies note that many communities studied have said that their rights have been violated, and in particular, structural and institutional violence can be seen, especially against women. It has been reported on numerous occasions how judges and prosecutors take advantage of indigenous people's lack of information and training in specific areas, especially their lack of knowledge of laws and regulations. This problem is exacerbated in the case of women with lower educational levels than men and with a greater proportion of illiteracy. Continuing on this theme, other types of institutional violence are more subtle and tend to go unnoticed, even by the indigenous women themselves, often not considering them to be "acts of violence". This is what happens with the exclusion of women from decision-making spaces, especially basing this on their "lack of technical capacity" to understand certain matters. Many public institutions do not ensure that their content or procedures are appropriate for women to understand their technical points, while internally too barriers can be seen to women's participation in decision-making spaces, where they are generally under-represented. (Oviedo, S; Alvarenga, F and Mongelós, N, 2012) [20]

Nationally, according to Luis Caputo (2013),[21] both domestic violence and trafficking in indigenous women are related to the dispossession of their ancestral lands that impacts their capacity to support their families (production and family food) exacerbated by existing models of economic development and the growing militarization of their territories.

17 Available at: http://ea.com.py/una-mujer-fue-asesinada-cada-11-dias-en-2012-por-razones-de-genero/.

18 Rachel Sieder and María Teresa Sierra. (2012). Acceso a la justicia para las mujeres indígenas en Latinoamérica. [Access to justice for indigenous women in Latin America]. Chr. Michelsen Institute, Bergen, Norway.

19 Grupo de Acompañamiento a Comunidades Indígenas de Itapúa – [Support Group for Indigenous Communities of Itapúa] GACII, (2014). Orientaciones para la Incorporación de la Perspectiva de Género en el documento "Propuesta de Políticas Públicas Elaborado por la FAPI. [Guidelines for Mainstreaming Gender in the document "Proposals for Public Policies Prepared by the FAPI (Federation for the Self-Determination of Indigenous Peoples)]. Itapúa, Paraguay

20 Sofía Espínola Oviedo, Faustina Alvarenga and Nora Mongelós. Desde la palabra y el sentir colectivo de las mujeres indígenas. Guía metodológica para incorporar el enfoque de género en comunidades indígenas, desde la perspectiva intercultural de abordaje. [From the collective words and feelings of indigenous women. Methodological guide to incorporate the gender perspective in indigenous communities, from the perspective of intercultural approach]. IEPALA – AECID, 2012.

21 Luis Caputo (2013). Situaciones de violencia y trata contra las mujeres jóvenes indígenas en Paraguay. [Situations of violence against and trafficking in young indigenous women in Paraguay] BASE/Sobrevivencia/IBISS-CO. Asunción, Paraguay, May 2013.

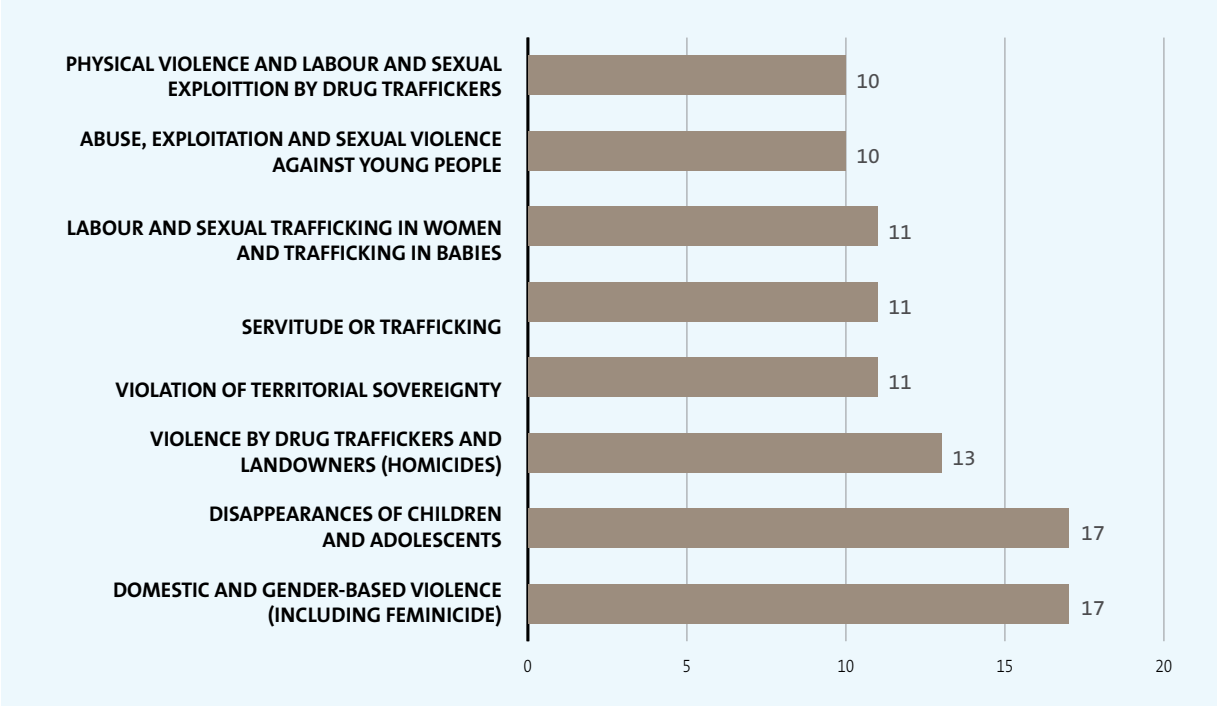
According to Caputo (2013), violence against indigenous women in Paraguay is domestic and gender-based, but he identifies how the different types of violence intersect and intertwine; for example, he identifies how labour exploitation intersects with sexual and institutional violence, or servitude with sexual abuse (rape).

On top of Caputo's (2013) findings can be added other types of violence that are hardly documented but that women from different peoples perceive as such. In the conclusions to the systematization of workshops on the prevention of violence against indigenous women in the departments of Amambay, Boquerón and Canindeyú,[22] indigenous women participants identified other types of violence, such as the cultural violence that is used to justify many of the acts of violence of which women and teenage girls are victims. One particular situation is that experienced by women exercising "shamanism" in some peoples, which has on occasion led to their deaths having been accused of "witchcraft". Behind this type of violence is the denial of indigenous women's right to exercise their power of healing and the full exercise of their spirituality.

In addition, an increase can be observed in violence against women who form inter-ethnic relationships with "Paraguayan" men (who are not members of any indigenous people), or the still current practice of the forced marriages of children and adolescents in some peoples.

**CHART 1**

**Types of violence against indigenous women in Paraguay as reported by female interviewees (Caputo, 2013)**




22 ConVoMujer/Tekoha/MIPY/GIZ. "Promoviendo la No Violencia contra las mujeres indígenas en nuestros Territorios" [Promoting non-violence against indigenous women in our territories]. Systematization of workshops on the prevention of violence against indigenous women in the departments of Amambay, Boquerón and Canindeyú. Unpublished report

# 5. METHODOLOGICAL ASPECTS

## 5.1 Type of study

To meet the general and specific objectives, a cross-cutting descriptive study with a qualitative approach has been proposed with the aim of characterizing the needs, barriers, strengths and opportunities of indigenous women and teenage girls with regard to violence and exposure to HIV, and to characterize the response to these situations at institutional and community levels, through mapping the actors in the communities included in the study.

## 5.2 Participants

### 5.2.1 Focus groups in indigenous communities

**TABLE 4**

| Community | Participants | No. of participants | People |
|---|---|---|---|
| Betania | Young men | 10 | Nivaclé |
| Betania | Adult women | 7 | Nivaclé |
| Betania-Yalve Sanga | Women and adult men | 15 | Nivaclé |
| Betania-Yalve Sanga | Adult women | 15 | Nivaclé |
| Yalve Sanga-Efeso Community | Adult women | 7 | Enlhet |
| Cacique Mayeto-Filadelfia | Women | 5 | Enlhet |
| Cacique Mayeto-Filadelfia | Teenage girls | 10 | Enlhet |
| Guidai Ichai Community | 16-year old | 1 | Ayoreo |
| Uje Lhavos Community | Teenage and young men (one woman) | 10 | Nivaclé |
| Cayin O Clim | Adult women | 7 women and 1 man | Nivaclé |

### 5.2.2 Individual interviews with representatives of institutions

**TABLE 5**

| Institution | Sector | Parent body |
|---|---|---|
| Paraguay Red Cross - Boquerón branch | Health | International body - Swiss Red Cross |
| Indigenous Clinic - Filadelfia | Health (private) | Filadelfia Hospital, under the Cooperative of Mennonite Settlers |
| Health Centre - Municipality of Filadelfia | Health (Municipal) | Municipality of Filadelfia |
| Regional Women's Centre | Women's, children's and teenagers' human rights | Ministry of Women |
| Government of Boquerón | Local Government | Executive |
| Municipality of Loma Plata | Local Government | Departmental Government of Boquerón |
| Cayin o Clim Family Health Unit (Neuland Colony) | Health (public) | Ministry of Public Health |
| Uje Lhavos Family Health Unit (Filadelfia) | Health (public) | Ministry of Public Health |
| Municipal Department for the Rights of Children and Adolescents (CODENI) - Filadelfia | Children's and adolescents' human rights | Municipality of Filadelfia |

## 5.3 Definition of variables and indicators

### 5.3.1 Indigenous women's and girls' need for interventions on HIV and violence

Variables will be explored related to the perceptions, expectations, needs and demands of indigenous women and adolescents with regard to the situation of violence (internal and external) and facilitating and protective factors linked to vulnerability to HIV and other STIs.

### 5.3.2 Mapping of actors and services

Variables were selected on the basis of the objectives of the consultancy and include organizations' profiles, their institutional capacities, and experience of inter-institutional coordination; also attitudes towards institutional participation in the development of actions targeted at indigenous peoples in the local setting related to violence and HIV.

**TABLE 6**

| Variable | Indicators |
|---|---|
| a) Perception and conception of violence | • Types of and scenarios for violence identified<br>• Actors involved in acts of violence<br>• Beliefs about violence. Reasons and causes<br>• Perception of violence as cause or effect of social determinants (gender, age, ethnic group, place of residence, education level, land ownership, poverty, access to resources, etc.)<br>• Perception of violence against adolescents and children<br>• Actions tried to address violence (internal and external) |
| b) Attitudes towards violence | • Justification of violence and gender norms<br>• Evaluation of violence depending on the aggressor (internal or external)<br>• (Early) sexual initiation, forced marriages and unions and placing children in domestic service (criadazgo) as an expression of gender-based violence or accepted cultural practices<br>• Culture of reporting, impunity |
| c) Beliefs, attitudes and behaviours related to exposure to HIV | • Beliefs and information about HIV<br>• Sources of information about HIV Level of trust and credibility of these sources<br>• Opinion of and acceptance of modern family planning methods, including the male condom<br>• Identifies risk factors and vulnerability to HIV and other STIs<br>• Practices tried to prevent HIV and STIs<br>• Perception of and attitude towards people living with HIV |
| d) Perceived self-efficacy (control over one's social determinants) | • Perception of risk of violence and HIV<br>• Belief about level of control over situations exposing one to risk of violence and HIV (ability to negotiate with men, control over exercise of sexuality, decision-making, control over children, ability to access health services, etc.)<br>• Identifies and lists the categories of gender, social class, ethnicity and age as factors in vulnerability to violence and HIV |
| e) Access to services and requesting support and help in cases of exposure to violence and HIV | • Types of services and resources available in the community identified by women<br>• Resolution strategies tried in cases of violence and exposure to HIV<br>• Opinions of these services and resources<br>• Perception of confidence in health services, police, justice system, local governments, NGOs, and community leaders, among others<br>• Opinions of costs and benefits in relation to seeking help or support in cases of violence or exposure to HIV (identify whether women perceive more barriers than potential benefits)<br>• Women's level of organization and perception of costs and benefits of participation in decision-making in the public sphere. Motivation for participation |
| f) Expectations and needs in relation to prevention of violence and HIV | • Needs felt and perceived by women vs. programme and political needs<br>• Basic and strategic interest of indigenous women and adolescent girls<br>• Expectations regarding services, bodies and actors available in the community (how they should be and operate depending on women's needs and interests)<br>• Definition/perception of health and quality of life and strategies identified to achieve these |

TABLE 7

| Variable | Indicators |
|---|---|
| g) Institutional profile | • Type of organization<br>• Mission and goals<br>• Thematic agenda<br>• Field of action |
| h) Institutional capacities | • Activities and actions conducted on violence and prevention, care and support related to HIV in indigenous populations<br>• Direct and indirect beneficiary population of actions<br>• Technical skills of human resources in the prevention of violence and HIV, and human rights, gender and intercultural approach<br>• Production of information on violence and HIV in indigenous populations<br>• Organizational, planning, material and financial resources for sustainability of actions |
| i) Inter-institutional coordination | • Coordination with other organizations on violence and prevention of HIV<br>• Coordination within health centres to offer comprehensive health/HIV services and care for victims of violence (PEP, testing, counselling, mental health, referrals to other social/justice services)<br>• Coordination with indigenous communities. Mechanisms for the participation of indigenous communities in decision-making<br>• Intersectoral activities<br>• Coordination procedures<br>• Links and coordination with other local bodies, especially with volunteer groups and networks of organizations and/or people |
| j) Attitudes and motivation of key actors to address violence and HIV in indigenous populations and women in particular | • Perceptions around the importance of the themes of the Project (violence and HIV, gender perspective and interculturality)<br>• Motivation to participate in the Project's key strategies at local level<br>• Programmatic and thematic interests<br>• Priority groups/organizations<br>• Coordination strategies<br>• Institutional commitment |

## 5.4 Design and validation of instruments

Data-collection instruments were developed from the objectives of the consultancy and from the variables identified for each specific objective. Both instruments were validated through review by the consulting teams and technical teams of the UNAIDS regional office, UNV and UN Women. The final versions of both instruments were used later for training the team of interviewers selected for the fieldwork.

## 5.5 Fieldwork

After validation of the instrument, the fieldwork was conducted using the following strategies:

a) Coordination with public institutions and civil society organizations working at Departmental level on the identification and selection of institutions and key actors in the selected municipalities/districts. A summary to present the scope and objectives of the study will be prepared.

b) Prior, free and informed consultation with indigenous communities covered by the study, presenting the project objectives and the agreed creation of a calendar of activities to be conducted, with the representatives of each indigenous community selected to gain access to women and teenagers for the focus group interviews.

c) Once indigenous communities, key actors, institutions and services had been identified, the consulting team issued a formal invitation to participate in the study through the appropriate mechanism, informing the selected bodies about the project in general and the activities of this consultancy in particular and introducing the team responsible for conducting the fieldwork.

d) After the formal communication to the appropriate bodies, the consulting team was responsible for coordinating an interview schedule with each community, institution, and key services and actors. Interviews with indigenous women, men and adolescents were conducted on-site through focus groups. The quality of information was assured by the proper use of the data-collection instruments provided. The consulting team held weekly evaluation and monitoring meetings to minimize any potential difficulties with the capture of primary and secondary information and to ensure the best quality of the data obtained.

## 5.6 Analysis of information

Information was processed using the process of data collection-systematization-consolidation-organization-analysis and dissemination.

- **Data collection:** Data were obtained at two levels: 1) Directly from primary sources (key informants from institutions and indigenous women from the communities) using group, individual and telephone interviews and the relevant information collection instrument; and 2) Complemented by data obtained from secondary sources (surveys, previous studies, institutional documents, etc.)

- **Systematization:** All the information obtained was organized and classified in ring binders duly coded with the sources of information, persons interviewed and the place and date of data collection. These documents were the means of verification which were used and whose information was taken and consolidated into a single database. This process is of the utmost importance since the resulting database can be later verified using physical verification means organized in ring binders in subsequent audits and evaluations.

- **Consolidation:** All the information obtained through the fieldwork process was consolidated into an electronic database designed for the purpose. This database was administrated by the designated consultants and it holds all the information on the variables present in the data-collection tools used.

- **Analysis of the information:** After the process of collection, systematization and consolidation of information, the information was analysed, taking account of the variables chosen. Interviews were transcribed and converted into text, which enabled qualitative analysis of the information, identifying similarities and differences in the contents of the informants' narratives; in addition to this, the variables explored using the checklist were classified and grouped in a database for their subsequent description and analysis.

- **Validity of information:** Validity will be ensured by 1) The representativeness of the sample to be interviewed. The consulting team, along with other key actors (community leaders, local representatives, etc.) identified institutions and actors representing all the sectors involved (Government, municipal, security forces, justice, health, civil society, confessional, etc.) ensuring that participation

was proportional and that no group or sector was over-represented. 2) Through triangulation, by means of cross-checking information from different sources (interviews with different actors, Government sources, civil society reports, multi-lateral and bilateral agency reports, national and regional statistical data, among others). In addition to this it was decided to interview members of the research team, since each interviewer had important and complementary information on the communities with which they worked. Not all the information obtained in the interviews is reflected in the recordings, since people give much relevant information outside the groups and interviews. All the interviewers had their field journal where they recorded and noted this type of information; and 3) All the information will be finally reviewed and validated by the Project Technical Team and representatives of the UNAIDS regional office, UNV and UN Women.

## 5.7 Structure, format and scope of data-collection instruments

**TABLE 8**

| Instrument | Objectives (as per ToR) | Technique and type of instrument | Source of information | Type of research | Validation method |
|---|---|---|---|---|---|
| **Interview guide for focus groups of indigenous women and teenagers from Boquerón** | | Focus group. | A sample of indigenous women and teenagers from selected communities of indigenous peoples from the Department of Boquerón. | **Field** Women were identified and selected who met the inclusion criteria set by the research team and focus groups were held for the communities selected. | Panel of experts. |
| **Semi-structured interview guide for key actors**<br><br>**Checklist for services** | Mapping and characte-rization of actors, bodies and services involved in the prevention of VAW and care for its victims and the res-ponse to HIV in Boquerón, focused on the indigenous population. | Individual interviews.<br><br>Observation and mapping of services. | Interviews with a sample of key informants selected previously, disaggregated by type of institution or organization (GO, NGO, private, confessional, grass roots group, networks, partners, etc.) and level of action (municipal, Departmental, national, regional)<br><br>In addition, different services and bodies in operation were visited to go through the checklist and characterize the level of response. | **Field** Key actors were identified and selected, as were services in the municipalities and districts of the Department of Boquerón that form part of the area of influence of the indigenous communities in the project. | Panel of experts. |

## 5.8 Ethical and cultural aspects

Women, men and teenagers participated on a voluntary basis. They were invited further to agreement by the men and women community leaders. Their acceptance was documented through their signing the "Informed Consent" form.[23] In addition, in each community the leaders, health posts, family health units and other key actors were given a printed copy of the summary of the scope and objectives of the study.

For this, they received verbal information in clear, culturally appropriate and accessible language on the characteristics, interventions and possible consequences of their participation. The team was accompanied at all times by a local link person and in some interviews by a representative of the local UN Women office.

Guidelines, questionnaires and other data-collection instruments were reviewed and revised by liaison persons in their own languages. The liaison persons accompanied the interviewers in the focus groups and individual interviews.

The final study document, and not only that of the research team, will be later given to the communities involved. Each time the fieldwork team conducts a mission, it will first visit the managers of the family health units nearest the community where the fieldwork is to be conducted in order for it to be aware of the work.

23 This document will be signed by the leader and/or parents as appropriate.

# 6. SCOPE AND LIMITATIONS

The study uses a descriptive, exploratory and qualitative approach, for which reason it is not possible to generalize its results to all the indigenous communities in Boquerón. Even so, due to the number and variety of informants interviewed it is a good approximation in relation to the situation that many indigenous women and girls in the study area experience.

As regards data gathering, the fieldwork was limited by time and resources from a greater geographic coverage, bearing in mind the distances between communities.

For this reason, all data were obtained in a single meeting with a set duration, which meant that much information was not captured. Indigenous peoples have different times and spaces than other cultures; they generally need more time to be at ease and provide information. The focus group methodology may not be appropriate for these cultural particularities.

Methodological approaches need to be identified and trialled that require more time for observation, for settling into the community to cross check what is said with everyday practice. (Ethnography and participant observation, among others).

With regard to teenagers and young people, the focus group is unlikely to be the best strategy for obtaining information. For this group in particular there needs to be a prior process and more experiential and participatory methodologies should be used. A good strategy would be to use the support of educational institutions and their teachers, who have formed links with the teenagers and who would be good facilitators for the process.

# 7. RESULTS

## 7.1 The needs of indigenous women and teenagers with regard to violence and HIV

### 7.1.1 Perceptions and attitudes about violence

A starting point for describing the cycle of violence experienced by indigenous populations and especially women and adolescents, is to investigate and describe the conception of this phenomenon from the world view of these peoples. Violence as a social phenomenon associated with inequality and unequal power balances in relation to ethnicity, social class, age and sex, among others, and especially man-woman relationships, is composed of an asymmetry whose relational function determines the status and power that one gender exerts over another, in this case, men over women, validated by the asymmetric and hegemonic patriarchal system. This definition of violence is defined and categorized as an offence within the regulatory and legal framework of Paraguay.[24] Nevertheless, the perception of violence also has a subjective element, since it is born in the "observer" of the events and this is mainly determined by culture in general and by other variables, particularly including social class, age and gender.

In this sense and starting from the subjective construction of which facts are considered to be "violence" and which are not, the following descriptive analysis can be reached from the particular visions of those interviewed:

In general terms, for every group interviewed, (adult women, adult men, adolescents and young men and women) violence was taken to be any act that led to observable, measurable and verifiable harm that implied some consequence or visible result. In this sense, violence could be taken as a synonym of "harm", "suffering" or "calamity".

"Violence is what does us harm, what causes suffering, what takes away tranquillity and what causes calamities. Where you see it most is in families and it has serious consequences for many families...because it touches people...if the husband beats the mother he leaves her with bruises, with swollen eyes through the blows, broken arms, and they kick her in the stomach or on the back; that is the worst thing one can feel or see in the home". *(Adult women - Cayin O Clim Community)*

"I saw a situation in one family that had a very big fight. I saw the man punching his wife in the face and then throwing her on the floor and kicking her, until she fainted. For me, this is a serious act of violence." *(Adult women - Cayin O Clim Community)*

"You realize straight away that you are facing a situation of violence...when you see that he is hitting her". *(Adult women - Cacique Mayeto Community, Filadelfia).*

24 Domestic, or intra-family violence is applicable to any person who suffers injury, physical, psychological or sexual abuse by one of the members of the family group, which includes that formed by kinship, marriage or common-law relationship, even if individuals are no longer living together. It is also applicable in the case of couples who do not live together and children, be they of both partners or not. Article 1, Law 1600 "against domestic violence"

But violence is not interpreted in every case as merely visible and verifiable physical harm. There is also "spiritual" harm, a harm that cannot be seen but that is felt and is troubling, taking away the "tranquillity" and "happiness" of the sufferer.

"Another of the types of violence that I see is, for example if the "cherub" (the partner or husband's lover) comes to me with some claim and tells me things that may offend me. That straight away makes me sad and takes away my happiness. This is violence as well, because it works on the mind and it is dangerous because it can kill you. Both parts (physical and emotional/spiritual) are dangerous, but before the great spirit too, someone who intentionally comes to offend you endangers your spiritual life. This too is a form of violence." *(Adult women - Cayin O Clim Community).*

"There is another form too, when they come every day challenging you and complaining. For example, in my household, in my home, if my husband says offensive things to me, that kills my spirituality and takes away my happiness. *(Adult women - Cayin O Clim Community).*

Other forms of violence are deception and infidelity, as is lying. They harm women's honour or violate the communal property of communities by people not from them.

"Another form of violence is when people say that you were unfaithful or have a lover but it isn't true and you know that it isn't true, that it is something they made up, and the more you say it isn't true the more your husband says that it is." *(Adult women - Cayin O Clim Community).*

"It is also violence when people or authorities come onto your territory without asking your leader, without permission. That's violence. For example, if we have a tightly defined territory and it is not respected...they are violating our internal order and our Constitution". *(Young men, Betania Yalve Sanga Community).*

On the other hand, it has been seen that in other communities at least the three main types of violence, physical, sexual and emotional, are clearly identified in a way that is closer to violence as defined at institutional level and addressed in the different Government plans and programmes. There is a new element appearing in the particular form of violence by children against their parents.

"Violence is suffering, when they say hurtful words to you...when they hit their children and sexual abuse is violence too." *(Adult women - Betania Community).*

"Another type of violence is children against their parents...our children get violent when they are drunk". *(Adult women - Betania Community).*

In addition to the above, particularly for the young women interviewed, the concept of violence was also linked to situations and behaviour that "break established rules" or "breach limits" imposed or agreed by persons perceived as legitimate authorities (family, parents, etc.).

"For me, violence is leaving the house without my parents' permission to go out to a party...getting yourself tattooed is another kind of violence...backchatting my parents would be another type of violence." *(Young women - Bethany Community)*

"There is my aunt who doesn't look after him (her son) or care for him. Her priority is playing volleyball and bingo, and I think that that's another kind of violence". *(Adult women - Bethany Community).*

In addition, unlike adult women and men's perception of violence, perceiving it as an external act whose aim is to cause harm (physical, emotional/spiritual or sexual), women introduced a variant of violence that is "towards oneself".

"My drinking alcohol at my age of 12 years is another form of doing violence against my person." *(Young women - Bethany Community).*

Regarding the drivers for these types of violence identified by interviewees, they unanimously and unhesitatingly focus on high alcohol consumption by males in general and by the younger men in particular. Here, the interviewers explored identification and awareness of the fact that other more distal or structural factors could also influence the phenomenon of violence, leading to greater or lesser vulnerability. Some respondents, however, could not identify the relationship between violence and other variables such as gender, ethnicity, age, poverty, discrimination, or lack of access to resources, goods and services, among others.

"We don't think violence is related to that (gender, age, ethnicity, financial position, access to resources, among other social determinants), but to alcoholic drink...Young people sometimes yell at their fathers, mothers, brothers and sisters because of drink." *(Adult women and men, Betania-Yalve Sanga Community).*

"Young people sometimes yell at their fathers, mothers, brothers and sisters." *(Young men - Betania Yalve Sanga Community).*

As an alternative explanation to alcohol abuse, women interviewed in particular sometimes perceive the economic factor as a possible cause of acts of violence, where the lack of resources could lead to conflicts within families.

"If there is no money, something is missing, they ask the mum and the mum tells him she doesn't have any and she abuses her son...and when it's like that the (alcoholic) dad also makes the house short of money." *(Adult women - Cacique Mayeto Community, Filadelfia)*

In some cases, among young men and women, violence is also perceived as a power imbalance, where one of the parties who has power exercises control through violence in order to subdue the subordinate party to the relationship. In this case, violence as a product of this power imbalance is interpreted not only as differences in physical strength, but the factor of economic power as a control and power strategy also comes into play. This, although it is not made explicit in the statements of some indigenous women, could be interpreted as an awareness that violence is also a manifestation of the subordination of women to men.

"Violence is an abuse of strength against the weak". "Indigenous women never speak up." "What drives violence is men's excessive jealousy and the lack of economic funding; it's from that too." *(Young men and women - Betania-Enlhet Norte Community).*

Nonetheless, beliefs can be discerned in some of the statements of the women interviewed that are related

to the empowerment of women as a protective factor against violence.

"My parents advised me and told me not to be a weak woman. They taught me to appreciate myself for who I am and to respect my family or my future husband, but without forgetting the value I have as a woman...I think that not keeping this advice in mind and not putting it into practice is what causes any kind of violence." *(Adult women - Betania Community).*

Some women have become aware of this change of role and that it has generated greater respect for them within the community.

"We are respected when we speak, at least in this community...Before, the only thing for women was gathering firewood and carob. All they could do was follow and obey the word of the chieftain, but there are no situations like that nowadays." *(Adult women - Betania Community).*

As regards perceptions of which groups are more vulnerable to being subjected to violence and by whom, a majority of interviewees, both men and women, identified the principal victims of violence as women, teenagers and children, with the main aggressors being males. The explanation for this distribution of roles would be the greater consumption of alcoholic drinks and in some cases of drugs by men, both young and adult.

Following this line of discourse, for young men too, acts of violence are mostly related to high alcohol consumption. Even so they introduce other explanations such as men's jealousy and lack of discipline, especially in the home.

"It can also happen that men are very jealous. And then they don't want their girls to be with other people and they start beating them." "They are very disobedient and then their mothers beat them." *(Young men - Uje Lhavos Community).*

As has already been described, just as with adult women and men, male and female teenagers also directly associate violence with the consumption of alcohol, especially by men, both adult and young. For this reason, many teenagers associate public spaces and in particular the streets and the weekends with a greater probability of violent events, given the greater consumption of alcohol in those spaces and on those days.

When and where is there most violence? "Fridays and Saturdays...when there are public holidays, that's when it starts." *(Young men - Uje Lhavos Community).*

Finally, members of the research team provide some input from their experience as interviewers and people who know the realities of the indigenous communities studied that reinforces or expands on what has been described in this section.

From the perspective of the interviewers, violence beyond the operational definition in the frameworks of institutional plans and programmes and the legal framework in force, is a "holistic" phenomenon that affects one's entire "spiritual being" and is not always a concrete, visible and measurable act.

"Violence is something that sucks at you, that saddens you...it is any act that harms the being and the spirit...when it affects the spirit you lose energy and life force...it isn't always measurable or verifiable, but something you experience (proven through experience), something you feel and that women recognize and communicate in different spaces, not always in formal interview spaces." *(Research team).*

In relation to the factors that drive these situations of violence, even though they agree with most of the indigenous interviewees, who name the consumption of alcohol and drugs as a recognizable factor, they go beyond this immediate factor and reflect on the "causes of causes", that is, the underlying determinants that are behind this high alcohol consumption in young and adult indigenous men and the gambling habits of one kind or another in which many indigenous women are immersed in some communities.

There is no doubt that the fundamental structural factor identified is the poverty in which these communities are immersed, which facilitates a series of conditions that ultimately propitiate the high alcohol and drug consumption and gambling described above.

Poverty, especially in the communities settled in urban centres, generates a chain of exclusions, job and sexual exploitation by persons external to the community, the promotion of consumerism, including the sale of alcoholic drinks, cigarettes and drugs, access to games of chance, overcrowding, etc. This exclusion is reflected in different areas that generate scenarios of high vulnerability to violence and exposure to HIV.

"The issue of structural violence is much normalized. It is noteworthy that they did say that, for lack of economic resources, that is, for 'being poor', they do not receive care or are mistreated in various services, such as health, public spaces, education, etc." *(Research team)*

On top of the violence resulting from exclusion that is in turn generated by a situation of extreme poverty, there is the variable of gender. Indigenous women are under the burden of a triple pattern of discrimination: the first is that of "being women", which weighs as heavily inside their communities as outside them; this is followed by the fact of "being indigenous", which is reflected as soon as soon as they access or request services external to the community; and finally, there is "being poor", which drives the process of exclusion even more.

### 7.1.2 Strategies to address and solve violence

It has been identified that the decision to report cases of violence is related to the perception of how serious they are, that is, the assessment of severity is given by the level of harm caused or the consequences for the victims.

"We have not yet seen a case of sufficient severity to report it." *(Adult women - Betania Community).*

Many cases would not be reported since they would not be considered to be of sufficient intensity or severity for an intervention; when these conditions are met, however, the first bodies to resolve cases that all those interviewed mention are the community authorities.

The first authorities to resolve conflicts and problems, including cases of violence, are the leader of the community, the Council and the pastors. If this authority does not yield a result or when the act of violence is extremely serious, people turn to institutions external to the community such as the police and the public prosecutor.

"First the Council meets and the Council calls the church, that is, the pastor, and the family affected is called to solve the issue. If there's no solution then it's straight to the prosecutor." *(Women and men - Betania Yalve Sanga Community)*

"We have a Council within the community headed by its leader, law enforcement and the pastor of the church. If the issue is not resolved within this Council and law enforcement, other action is taken. Take it to the police station or prosecutor." *(Young men - Betania Yalve Sanga Community)*

"According to the by-laws of Yalve Sanga CNU (United Nivaclé Community)...it says at the start of the by-laws, first it has to be resolved in religion (with the pastor), and if that is not respected talk with the leader and law enforcement and if that is not respected take it to the national police and if there is no solution make a complaint directly to the prosecutor (these are the bodies we have to use if violence occurs in our community, and what is stated in the by-laws)." *(Woman and men - Betania Yalve Sanga Community)*

The strategy for resolution used by these authorities, it seems, is to mediate between the parties concerned and the solution tends to be (in lesser cases) that the parties be reconciled.

"If it is not so serious, we succeeded in having them forgive one another again" *(young couple case). (Women and men - Betania Yalve Sanga Community)*

For another sector of young people, violence also implies a certain "complicity" by the person affected, that is, the very woman who does not report these acts for fear of losing benefits, especially financial benefits in cases where the man is the main provider of economic resources for the family.

"But what happens when you meddle in someone else's family? They tell you not to get involved in our problem, because the partner herself (the woman) is consenting to this violence within the family...there is complicity, the woman who says, 'if they take my husband away (detained or arrested) nobody is going to bring me food here (in the home)...that's the excuse, and nothing gets finished." *(Young women and men - Betania-Enlhet Norte Community).*

In the account above it can be seen how the economic factor exerts influence on decision-making by women exposed to situations of violence. In most cases women are economically dependent on their partners since it is the latter who are the main providers of the home, and that is why losing this financial support could be perceived by many women as a situation even more threatening than exposure to violence itself.

This "complicity" on the part of the victim of violence described by some interviewees (not reporting their partners to external state authorities such as the police, the prosecutor or the justice of the peace) seems to be reinforced and legitimized by the bodies charged with dealing with these problems within the community: the community leader and the Council, reluctant to involve bodies external to the communities and opting to resolve them internally.

Informants recognize the power and authority of these bodies. Even above the very institutions of the State.

"The leader, together with the Council of the elders, they have the power to resolve internal problems; it is ultimately possible to make a report to the national authorities. It is a right that every community has...in fact the police are not allowed to enter the community after 6 o'clock (in the afternoon)...up to 6 o'clock they are allowed in, but after that they have no right." "The leader has absolute power like any judge; if the leader is wrong they are all wrong...so the person elected as leader is judge, scribe, lawyer, and everything." *(Young women and men - Betania Enlhet Norte Community).*

"First, the Council meets and the Council calls the church, the pastor and the family affected is called to resolve it. If there is no solution then it's straight to the prosecutor." *(Young men - Betania Yalve Sanga Community).*

There is a perception, especially in some adult women interviewed, of great confidence in the authority and power of the community's pastor to resolve conflicts, which would strengthen even more the role of the pastor beyond the pastoral and spiritual, so that they even have an institutional role as mediator and administrator of family and community conflicts with the authority to impart justice in cases of harm and reparation.

"When there are family problems they go to the church, to the pastor...because pastors know a lot...when someone sees violence in the street or in the family they have to inform the pastors." *(Adult women - Efeso Community, Yalve Sanga).*

"The only action we can take is to take matters to the Council of elders and the pastors as mediators. They talked with the family or the partner and it has always been successful." *(Adult women - Betania Community).*

Apparently, the authority of the church through its representatives (the pastors) is not only legitimized by the community, which perceives them as key actors with authority, but this authority is based in the very by-laws that govern the organization of some communities. The pastors are also the first resource when people are seeking help and support and it is only when this resource is exhausted that people turn to the leader of the community and to public institutions.

"It says at the start of the by-laws, first it has to be resolved in religion (with the pastor), and if that is not respected talk with the leader and law enforcement and if that is not respected take it to the national police and if there is no solution make a complaint directly to the prosecutor (these are the bodies we have to use if violence occurs in our community, and what is stated in the by-laws)." *(Young men - Betania Yalve Sanga Community).*

In contrast to this, little confidence is perceived in the institutions and organs of the State. They say that the police and prosecutor "take no notice of indigenous people", only of white people. The common perception is that resorting to these authorities external to the community does not generate greater benefits and on many occasions it has no positive result, and that is why they go back to internal conflict-resolution bodies (leader, Council and pastors).

"We turn first to the authorities in the community. I'm not talking about other families, I'm talking about my family." *(Adult women - Cayin o Clim).*

"Not one (talking about results of complaints to authorities external to the community such as the police or prosecutor)...they are stalled (the complaints), they are filed away in the prosecutor's office and I think that the rats have already eaten the lot." *(Young women and men - Betania-Enlhet Norte Community).*

"If the person is indigenous they take no notice of them if they make a mistake...it's not our problem say the police. If they're white, it's a different matter." *(Young men - Betania Community, Yalve Sanga).*

In relation to the youngest, a reactive attitude is identified, most particularly in the group of young men, that is, violence towards them must be responded to with equal or greater violence, as a resolution strategy.

In the extract from the interview with a focus group of young men, it is observed how this cycle of violence begins and how violence is conceived as a strategy to solve problems, its main objective being to destroy the opponent.

In this extract it can be seen how violence is conceived as a tool of control and power necessary in the face of

a threat that is always perceived as external (violence is an act from outside that must be responded to).

If someone assaults you, hits you? I'll respond... Will you respond in kind? We'll react very quickly...And in what way will you react? If they pull my hair, I'll do the same. If they insult me with something very rude I'll say something worse back, and that's how the fight begins...And do you have any way of solving things before it comes to this abuse? Yes. I'll be able to solve it, but the other person won't want to, because that is what they're all like, they won't want to. He's going to be too angry and he's going to want to fight to get the anger out...Do they have to get this anger out from inside in some way? Yes. If he hits us and we leave it at that...we have to react. *(Young men - Uje Lhavos Community).*

In relation to the pattern for seeking help in the event of violence, just as with adults, the main resource for young people with the authority to manage conflicts within the community is the leader, and they say that they are not aware of any other resource.

"We always call the leader" (in cases of acts of violence). *(Young men - Uje Lhavos Community).*

And according to adults, when male and female adolescents are the victims of violence, they usually do not report it at all, for fear and shame.

"They are ashamed (teenage girls)...girls hide and do not want to show themselves." *(Adult women - Cacique Mayeto Community, Filadelfia).*

The research team carried out an analysis crossing the variables of gender, ethnicity and poverty as factors to explain the processes of discrimination and exclusion that women especially experience both within their communities and in external scenarios.

Being women, at the internal level leaders do not often take account of their needs or demands, all the more for minor issues or situations that affect children or the elderly, taking it as read that these are the natural protective roles of women and their responsibility.

Many women tell us, "they don't let us take part and if we speak they take no notice of us." *(Research team).*

And neither are their voices taken into account when they seek services external to the community.

"Although it wasn't made clear in the focus groups, outside the formal space of interviews indigenous women describe the various forms of discrimination as constant forms of violence against them, such as the strong discrimination they suffer in public health services on account of being poor and indigenous, because they do not speak Guaraní or understand little Spanish. The lack of interpreters and translators in health services, in the prosecutor's office, the national police, the courts, etc. are viewed as a form of discrimination and social exclusion." *(Research team).*

"Because they are women, public institutions take no notice of their complaints, reports or requests, unlike men who are automatically accepted as leaders...For example, in the departmental government they say, "that doesn't give us balls"...and they even disinfect meeting spaces when meetings are held with indigenous people present... but it's even worse for women because they are sometimes not even invited." *(Research team)*

TABLE 9

**Summary of findings on issues related to perceptions, attitudes and decision-making related to violence**

| Dimension | Main findings |
|---|---|
| **Perceptions around violence** | • Acts that generate physical, observable "harm" (men) or "spiritual" harm (women) that cannot be seen but are "felt".<br>• Deception and infidelity (women).<br>• Violating community property (men and women).<br>• Situations that violate standards/limits or break rules (young men and women). |
| **Factors related to violence** | • Consumption of alcohol and other drugs (all groups).<br>• High levels of free time, generating gambling addiction (women).<br>• Poverty, exclusion and overcrowding (research team and women).<br>• Imbalance of power, control and subordination (young people).<br>• Violence as a conflict-resolution strategy (young men).<br>• Lack of discipline in the home (young people and women).<br>• Empowerment of women as a protective factor (women).<br>• Triple pattern of exclusion: being female, indigenous and poor (research team and women). |
| **Groups perceived as more vulnerable** | • Children and adolescents:<br>• Young people.<br>• Women. |
| **Strategies to address violence** | • Cases are reported depending on an assessment of the severity of the perceived harm (visible physical harm).<br>• First resource for resolution: community authorities (leaders and Council).<br>• Important role of the church and its pastors for resolution of acts of violence.<br>• In cases of extreme seriousness or when community resources and the churches do not solve the problem, recourse is had to external institutions (police, prosecutor, etc.). |

### 7.1.3 Beliefs, attitudes and behaviours related to exposure to HIV

Everyone interviewed, regardless of age or gender, said that they had heard information about HIV and were able to correctly state the forms of transmission and means of prevention. They perceive HIV as a threat to the community and the notion exists that it is a disease caused by a virus that has no cure. They also recognize other factors that affect the course of the disease (diet, stress, environment, adherence to treatment)

"HIV is a virus, a bug, that you get and which is there, but when you do not eat well, when you are afflicted a lot, when your defences are down, it is then that the bug starts multiplying. But when people live well, look after themselves, eat well, don't get drunk or take drugs, live quietly and have a good atmosphere at home, everyone likes them and this environment looks after people and if there is no affliction they can live and will die of something else, not this (HIV). But they have to unfailingly take their medication all their lives." *(Women and men - Betania Yalve Sanga Community).*

"We know that it is an incurable disease and we try to warn our people because there's no medicine for that (prevention)." *(Adult women - Betania Community).*

While HIV is perceived as a threat, there is a belief among some groups that the epidemic is foreign, external to indigenous reality, and that those with the main responsibility for introducing the virus into the indigenous communities are foreigners (including Paraguayans).

"For example, this HIV is not a disease that broke out among indigenous people...it is not a disease of indigenous people...our ancestors never died of AIDS." *(Young women and men - Betania-Enlhet Norte Community)*

The perception of risk is focused on causes or factors related to individual sexual conduct (having several sexual partners, sex work, non-use of the condom) and other predisposing factors such as alcohol. Distal or structural factors, such as discrimination, poverty, or lack of access to resources, goods and services, are not perceived. For this reason the focus is on personal decision and responsibility for infection is purely individual, with no perception of other factors or social determinants that influence people's decision-making.

"Before, nobody knew about or had heard about this disease. Nowadays, as every one of the participants says, they themselves were searching, they were preparing their way of life, disease. The individual makes his or her own life." "The community does not really know what HIV is (incurable disease). But it needs to know it well. Some people listen to the radio and it talks about this." *(Woman and men - Betania Yalve Sanga Community)*

The belief that HIV is a disease of "other" (non-indigenous) people and that it is purely determined by individual behaviours related to sexuality, without identifying other social determinants such as gender, age, ethnicity, socioeconomic status, discrimination and barriers to accessing a series of resources, goods and services. These beliefs could create a distorted perception of risk that could hamper correct decision-making on sexual matters (98 per cent of HIV cases can be explained by having sexual relations using protection), exposing members of indigenous communities to situations of high vulnerability.

While the means of transmission and methods of protection are known, a low rate of condom use is declared, often due to the influence of the pastors in the community. In some cases, the condom is seen as a necessary evil, given the consequences of not using it.

"Condoms are not used. They are not mentioned, the pastors don't talk about them." "If someone goes to ask for one, that's a bad example." Something to avoid, but something mad if it raises the awareness of young people, they are going to go to work to buy this condom and then where will that get them, but it's better too. That is why we are where we are." *(Women and men - Betania Yalve Sanga Community)*

In addition, there are beliefs that lead to negative attitudes regarding the use and effectiveness of the condom as a means of protection: men maintain the belief that condoms "may break" and some women are afraid that the condom may "remain inside them".

Like the group of adults, when young men and women were questioned on the risk factors they identified for HIV infection, they all focused on sexual behaviour: non-use of the condom, sexual activity at a young age, multiple sexual partners, sex work and same-sex relations. They identified no relationship, however, between increased risk and vulnerability to HIV and determinants other than sexual behaviour: Being

a victim of violence, being poor, early and/or forced marriage, and barriers to access to health services.

The young people interviewed perceive no relationship between vulnerability to HIV and other more structural social determinants of health. The only risk factor perceived is that of individuals' behaviour.

Among all the risk factors identified, the one highlighted as bringing the greatest risk is same-sex relationships, specifically men having sex with other men.

#### 7.1.3.1 Sources of information and trust in them

The Betania community radio station, which broadcasts in the Nivaclé language, is one of the main sources of information apart from health services. The church is another important source of information. It puts out messages that contradict the information given on the radio and by the health services, where the condom is promoted as the main health strategy for HIV prevention, in contrast to the message promoted by the churches, based on abstinence and mutual fidelity.

In other communities, such as Efeso, school is identified as the main source of information about HIV prevention; there are also health posts and the talks that the health posts organize on occasions.

"On the radio. We listen to health programmes on the community radio station that is under station ZP30, which they broadcast in Nivaclé. There is community radio in Yalve Sanga (every Wednesday). They teach us and give us information. The nurses don't always have time. *(Adult woman and men - Betania Yalve Sanga Community)*

"Congregations and pastors raise awareness. Someone else's woman, for our creator, is a great sin." "People who don't believe will fall into grave sin or an incurable disease, says the Bible." *(Woman or man, Betania Yalve Sanga Community)*

"When we have questions about HIV or any disease we go to our community clinic or health post." *(Young women and men - Betania-Enlhet Norte Community)*

It is perceived that participation in activities to learn about and prevent HIV and about sexual and reproductive health is the exclusive responsibility of women, with no male participation.

"They have brought us talks about sexual health for every community and it is practically all women there; there is not a single man at the talk... and men don't go to the clinic either; it is always we women who go for check-ups." *(Adult women - Betania Community).*

With regard to young people and teenagers, both genders mostly identify school and college as their main source of information on HIV and other sexually transmitted infections. The main providers of information are teachers and, according to what was reported by respondents, teachers are trustworthy sources of information on this matter.

#### 7.1.3.2 Attitudes towards PLWH

Antagonistic attitudes towards indigenous people living with HIV in the communities are detected. Women tend to express more maternalistic attitudes, where support and compassion are the most appropriate approach, but males tend to see this situation as a threat and have, on occasions, demanded that

health services provide the names of PLWH in order to "protect the community", adopting a more controlling and punitive attitude.

"No. In the community we don't know of anyone (living with HIV) but if there was someone going through that we would be compassionate towards them and give them our support." *(Adult women - Betania Community).*

"That's why we say that if there are any (people living with HIV in our community) that would put us all in danger...so how are we going to protect ourselves if nobody knows who has AIDS, right?" Our grandparents told us that when someone had syphilis, the village was told, watch out for this one who has syphilis (at that time), but the man giving the talk (from the Ministry of Health) said that this (revealing the identities of PLWH) is not possible." *(Young men - Betania-Enlhet Norte Community).*

**TABLE 10**

## Summary of findings on beliefs, attitudes and behaviours related to HIV and AIDS

| Dimension | Main findings |
|---|---|
| **Knowledge, attitudes and perceptions of risk** | • Good knowledge of means of transmission and methods of prevention of HIV and other STIs.<br>• Basic knowledge of HIV (notion of a virus that destroys the body's defences).<br>• Perception of threat of HIV and that it is an incurable and potentially deadly disease.<br>• Perception of the disease as foreign (a disease of others).<br>• There is a perceived risk in behaviours linked to sexuality: multiple sexual partners, becoming sexually active at a young age, same-sex relationship between men, and sex work.<br>• No direct risk relationship is perceived with other social determinants: gender, ethnicity, poverty, discrimination, etc.<br>• Risk is perceived as an individual decision: responsibility for infection is personal.<br>• Negative attitude towards the male condom and low condom use Influence of the church on its non-use. |
| **Sources of information and credibility** | • Community radio (in the Nivaclé language).<br>• Health services.<br>• Churches.<br>• Educational institutions: teachers are seen as credible sources on this topic. |
| **Attitudes towards indigenous people living with HIV (PLWH)** | • "Maternalistic" attitudes: understanding, support and care (women).<br>• "Controlling and punitive" attitudes: PLWH perceived as a "danger" to the community, for which reason they are to be "identified" and placed under "control" (men). |

### 7.1.4 Access to health services and requests for support in cases of violence and exposure to HIV

#### 7.1.4.1 Sexual and reproductive health services, including HIV

With regard to the use of family planning methods, adult respondents said that they used traditional methods such as the pill and injections for the women. A majority said that decisions on how many children to have and methods of family planning are made as a couple. Nevertheless, some women said that men still have great influence on women's reproductive decisions, since many husbands and partners "disapprove" or even "get angry" when women use methods provided by the health services without the man's "knowledge".

There are two routes to accessing health services. One of these is that access to the network of public health services is completely free for everyone and, the second is that some members of the communities access a social insurance scheme (a mutual) for which they have to pay 5 per cent of their earnings. This insurance is under the Mennonite settler cooperatives and to be a beneficiary of it, one has to have some kind of work relationship with settlers. If the indigenous person does not pay the insurance, he or she has to go to a public service where he or she can also receive family planning supplies free of charge.

"In our case, if we pay the insurance, the insurance covers us, that is, we can access health care. But if we don't pay, we go the San Miguel health centre (Villa Boquerón). In this public centre we have access, but in the other one it is hard for us if we don't have money." *(Adult women - Betania Yalve Sanga Community)*

Although, as mentioned, reproductive decisions are made as a couple, family planning remains the almost exclusive responsibility of the woman, that is, the main birth control methods are the pill or injections (methods for women) and little or no use of male condoms (methods for men).

While respondents say that in most cases the number of children and the frequency of births is a shared decision, it is identified that the main factors influencing this decision are the economic resources to support a large family and the number of children; the more children there are, the more likely it is to decide to use some method of family planning.

Barriers to accessing health services are perceived. Firstly, the services managed by the Mennonites are not totally free (except for the basic Ministry of Health programmes), and they have to be paid for; on other occasions, when they access a public service they find that some health providers "recommend" that they go to "their hospitals", that is, to indigenous health services. Many interviewees perceive discrimination against indigenous peoples in some health services.

"We trust the health centres and we are satisfied with the outcomes. But there ought to be more trust among the Mennonite doctors towards indigenous women, and men too. It's just that we have to have money for them to treat us." *(Women and men - Betania Yalve Sanga Community)*

"For lack of money often. There are no sources of work; it's difficult. They treat us in the San Miguel health centre in Villa Boquerón, but sometimes the doctor at the centre, which is public, says: Why don't you go and get treatment at your hospital? (off microphone the interviewee says: they make fun of us), but they still treat us. You have your hospital, they say." *(Women and men - Betania Yalve Sanga Community)*

On the other hand, in some communities women said that conjugal status was a criterion for accessing

**BOX 1**

### Summary of findings related to access to health services

- All services provided by the Ministry of Public Health free of charge: HIV and syphilis screening and antenatal care.
- Sexual and reproductive health activities are mainly aimed at adult women with little or no participation by adult men and teenagers.
- Decisions on having children and sexual health are taken jointly and in some cases solely by male partners.
- Majority use of modern family planning methods: contraceptive pill and injections.
- Provision of HIV test is biased. It is only offered to women who are pregnant or to people with some risk factor (sex workers, men who have sex with men, etc.). It is not offered to all sexually active persons.
- Discrimination is perceived in some health services.

supplies for protection and family planning, that is, women who are single or without a stable partner would have greater difficulty in accessing supplies.

"There is a list of women who go to get them (pills), but they have to be a married lady, who has a partner." *(Adult women - Efeso Community, Yalve Sanga).*

Even so, regardless of type of access to the health service, they all have Ministry of Public Health programmes, including screening for HIV and syphilis free of charge, even in services that are not part of the public network.

The difficulty perceived with testing is a bias when offering HIV and syphilis tests, since providers tend to offer these only to pregnant women and some women with certain risk factors, and not to men or younger people.

Another important barrier for people with a confirmed diagnosis is the distance between test centres and the referral centre for the diagnosis and treatment of HIV. The Comprehensive Care Service only operates in the Boquerón Regional Hospital, located in the town of Mariscal Estigarribia, 600 kilometres from some of the communities interviewed for this study. This would mean investing economic resources and time on a monthly or bimonthly basis to access the only referral centre for HIV in the Department of Boquerón and, in some cases, this would be a barrier to correctly following treatment.

#### 7.1.4.2 Response to violence

As described above, there is a consensus in all the interviewees that the first place to go when seeking help in the event of violence is the leader of the community and the Council and the pastors of the evangelical churches are also valued as mediators in this type of situation.

This type of internal-level intervention described would, in some cases, conflict with national legislation on violence, which establishes a care protocol and referral flow diagram,[25] and what is more, the legal

25 Anyone affected may report these events to a local Justice of the Peace verbally or in writing, in order to obtain protective measures for his or her personal safety or that of his or her family. Interventions will be free of charge. In cases where the person concerned is not able to make the complaint in person, family members or persons with knowledge of the event may do so. In cases where the report is made to the National Police or in a health centre, it will be forwarded to a Justice of the Peace immediately. Article 1. Law 1600 "against domestic violence".

framework stipulates that after checking the credibility of the complaint, a series of urgent measures are to be put in place to protect the victims, among which are stated: a) Order the exclusion of the alleged perpetrator from the home where the family group lives; b) Prohibit the alleged perpetrator from accessing the home or places that imply danger for the victim (Law 1600, article 2).

Two distinct approaches can be identified in this case. One of these is within the community through its legitimately constituted authorities (leaders and Council) and through the influence of the pastors of the evangelical churches, whose representatives are considered community authorities, who would tend to maintain the link (family) between the aggressor and the victim, working for the victim to remain in the same residence as the aggressor. In the second, the institutions of protection (Prosecutor, Directorate of Prosecutions, Justices of the Peace), obliged by the legal and regulatory framework in force on domestic violence, have a mandate to protect the victim, in this case the woman and her children, through the immediate and urgent implementation of measures which involve, in some cases, restricting the aggressor's access to the victim (exactly the opposite of what is recommended by community authorities).

For younger people, this organization of the exercise of authority and the duty to impart justice within the communities creates a power imbalance, since in these resources (leader, Council of elders and, in some cases, pastors) participation by women is forbidden, these being exclusively male decision-making bodies. In this regard it is perceived and acknowledged that women's rights are far from guaranteed when justice is imparted and community problems resolved.

"Sadly, in our community women's rights have not been, up to now, let's say, guaranteed because as we always say in our community, there is customary law and no (external) authority can enter that and impart justice within the community, because there is a leader who doesn't want the (external) authorities to meddle, and there is also, sadly, the complicity between one leader and another." *(Young women and men - Betania- Enlhet Norte Community).*

Regarding access to health services and knowing about the authorities responsible for violence, young people and adolescents say that they do not know what authorities to turn to in the event of violence and only recognize the leader of the community as the authority for resolving problems of this type. With respect to health services, while they know of the services close to their communities, they do not use them to ask for condoms as they say that they would be embarrassed to do so. In this regard, the condom is known to young people and they recognize its function, but they do not use condoms when they embark on sexual relations.

**BOX 2**

### Main findings related to the approach and response to violence

- Conflict between the approaches of the community and the institutions: community and church authorities tend to resolve the conflict without breaking up the couple. At institutional level, the protection of the women and children is sought through actions to restrict or exclude the aggressor.
- Decisions of community and church authorities are perceived as biased: these authorities are almost exclusively composed of men.
- Young people and adolescents cannot identify the institutional bodies to use if they are victims of violence.

### 7.1.5 Expectations and needs in relation to the prevention of and response to cases of violence and exposure to HIV

In general terms, interviewees identify needs and expectations that could be grouped into three distinct categories: improved health services, greater participation in decision-making, and better education on HIV and violence.

#### 7.1.5.1 Health services

Demands in relation to health services are focused on two basic needs:

1) Having health services exclusively for indigenous people in their communities is perceived as a necessity, a right and a way of avoiding conflict with non-indigenous people.

> "There is always conflict, and there should be a clinic or hospital for indigenous peoples. To avoid conflict towards indigenous people. (There is also discrimination in Villa Choferes, Mariscal Estigarribia, The Latinos' Health Centre, the Mennonites)" *(Woman or man, Betania Yalve Sanga Community).*

> "Because in the Latinos' (health) centres they don't want to treat indigenous people." *(Woman or man, Betania Yalve Sanga Community).*

In this respect, there is a conviction that having exclusive health services could ensure better care for indigenous people. Furthermore, there is a perceived lack of trust in using non-indigenous health services since cases have been reported of abuse, discrimination and the perception that in these places non-indigenous people are treated "better".

2) More medicines and health professionals to treat indigenous people with quality and warmth, in sufficient numbers to meet patient demand, and geographically accessible.

> "There is a difficulty in health care through the lack of permanent doctors providing good care." *(Betania focus group in the Agustín Juárez group)*

> "The doctor is full of things, he is asked for census, he is asked to enter data and the consultations he does, two or three people there (in the health service) cannot be the solution for 7,000 people." *(Betania focus group in the Agustín Juárez group)*

> "We have an indigenous hospital located 400 or 600 kilometres away, which is no use to El Chaco. It is better to do things in central El Chaco. Because they sometimes move patients and halfway there they cannot hold out any longer and they die." *(Woman or man, Betania Yalve Sanga Community)*

Some barriers identified in health services attended by people from the communities interviewed are related to a lack of supplies, health staff work overload impacting good patient care (patients have to wait a long time to be treated) and geographical barriers, especially the long distances they have to travel to reach some health services.

### 7.1.5.2 Greater participation in decision-making processes

In some groups, of both men and women, a need is perceived to promote greater participation in decision-making processes, especially in positioning themselves as valid interlocutors for decision-making bodies (local Government, such as Departmental and municipal, and institutional bodies of the State). To achieve this goal, they identify the need to better "know" and "understand" how participation processes work. On the other hand, they value the joint work between the different bodies and recognize that in order to exercise their rights they must first of all find out what they are.

"We need to know a little more what the roles are of the State, the municipality and the Department. We don't know their specific roles and that is why we do not claim things that are our right... we need to know more and have more dialogue with the Governor, mayor and others to get to a point where this community near Filadelfia does not suffer from the diseases that they suffer from far away with no chance of getting to a health centre." *(Betania focus group in the Agustín Juárez group).*

Organization, of both indigenous men and women, is seen as a first step towards participation and empowerment.

"We have an organization composed of seven people...we are gaining confidence within our organizations, both women's and men's organizations, because we are talking more." *(Betania focus group in the Agustín Juárez group).*

Nonetheless, organizing does not always mean having political goals for participation in public spaces, but rather, many women are getting organized for religious purposes and sometimes conduct solidarity and welfare actions.

"There are 12 women on my committee. We have a secretary, second secretary, a treasurer and adviser...there are women with experience of talking about the Bible...we are visiting house by house; we hold meetings and we sometimes take songs and prayers to the women too...and we fast as well to pray and improve families." *(Adult women - Cacique Mayeto Community, Filadelfia).*

### 7.1.5.3 Services related to addressing violence

In relation to the issue of violence, no specific or concrete needs or expectations are identified in the interviews.

Nevertheless, needs are more oriented towards strengthening the capacity to respond of internal authorities such as leaders and councils, as well as the pastors, who are considered key actors to address situations of this type. Demand in this latter case would be for greater support from community leaders and pastors.

"They need to support so that there are no more fights or alcohol consumption...the pastors need to give more advice." *(Adult women - Efeso Community, Yalve Sanga).*

Unlike adults, a majority of teenagers feel a need for more education for both mothers and themselves in their native language to generate more and better understanding on these issues.

"We have few or no talks on violence, even though they do give is information on sexual health in school...they organize activities in the church but not on violence, rights and so on, and that is why we don't understand too well how many types of violence there are." *(Young people - Betania Community).*

"We want clear information on violence, HIV and syphilis and their consequences." *(Young people - Betania Community).*

Young men identify it as a need to have greater safety and space for young people to meet and be educated. While they acknowledge that there are youth groups, these are part of confessional groups in which only members of the churches participate.

"In the church there are (youth groups) and meetings for young people from there...for those who are members of that church." *(Teenagers and young men - Uje Lhavos Community).*

Some young people interviewed do not identify with either the churches or school, since they attend neither of these institutions. For them, school is not a point of reference for awareness-raising activities and education on HIV and violence. While they do see the value of taking part in activities of this type, they are very interested in peer intervention strategies, putting traditional methods (workshops and talks) to one side and adopting innovative strategies in their place such as educating and raising the awareness of the community and young people through theatre or other arts activities.

**TABLE 11**

## Main expectations and needs identified in relation to violence and HIV

| Adult women and men | Young and teenage women and men |
|---|---|
| • Education on HIV tailored to men, women and young people.<br>• They recognize the importance of having health promoters and indigenous volunteers in the community.<br>• More information and communication activities with intermediaries who can translate into their native language. A need is felt to understand and comprehend exactly what HIV and violence involve and how to prevent them.<br>• They recognize the value of community radio in their mother tongue as the main means of providing more trustworthy communication and information.<br>• Strengthen local organizations to give them greater power to resolve situations of conflict or problems that arise in the community.<br>• Take action to prevent alcohol and drug abuse by young indigenous people (the main problem identified by most respondents). | • Identify youth leaders and informal young people's groups (outside the youth groups in the churches) to develop strategies to raise awareness, educate and empower, using unconventional techniques such as theatre or similar activities.<br>• Identify and invite the leaders of existing youth groups (in churches and schools) and train them as peer educators in the prevention of HIV and violence.<br>• Harmonize and coordinate actions and efforts among the family health units, leaders or clans in the community, schools, churches and young people to design and implement prevention campaigns. |

TABLE 12

**Main expectations and needs identified in relation to violence and HIV**

| Institution | Sector | Parent body |
|---|---|---|
| Paraguay Red Cross - Boquerón branch | Health | International body - Swiss Red Cross |
| Indigenous Clinic - Filadelfia | Health (private) | Filadelfia Hospital, under the Mennonite Settler Cooperative |
| Health Centre - Municipality of Filadelfia | Health (municipal) | Municipality of Filadelfia |
| Regional Women's Centre | Women's, children's and teenagers' human rights | Ministry of Women |
| Departmental Government of Boquerón | Local Government | Executive |
| Municipality of Loma Plata | Local Government | Departmental Government of Boquerón |
| Cayin o Clim Family Health Unit (Neuland Colony) | Health (public) | Ministry of Public Health |
| Uje Lhavos Family Health Unit (Filadelfia) | Health (public) | Ministry of Public Health |
| Municipal Department for the Rights of Children and Adolescents (CODENI) - Filadelfia | Children's and adolescents' human rights | Municipality of Filadelfia |

## 7.2 Analysis of available services for HIV and the prevention of violence / care for victims of violence

To characterize the institutional response to violence and HIV in the Department of Boquerón, a sample was taken of nine institutions working in both areas.

The institutions that agreed to interviews were:

### 7.2.1 Institutional capacities

#### 7.2.1.1 Activities and actions

It is evident that health institutions are over-represented in the region and that there are a few institutions working on human rights issues, including violence against women, children and adolescents. This would seem to reflect the unsatisfied basic health needs of the populations of these municipalities and departments, in relation to the need for prevention, protection and care for the victims of violence in all its forms.

Nonetheless, every institution, except the Regional Women's Centre and CODENI in Filadelfia, reported that it does work on sexual and reproductive health and HIV, especially in the field of prevention, since all these institutions have staff and actions targeted at communities through information-giving and educational talks and workshops, especially on the prevention of HIV and modern methods of family planning.

In relation to care and support for HIV, every health centre has voluntary, free testing for HIV and syphilis

using rapid tests. In the event of reporting a positive result, patients are referred to the Regional Hospital of Boquerón, the only Comprehensive Care Service with a laboratory, medical care and a pharmacy with antiretroviral drugs (ARV) in the whole of Chaco Paraguayo.

For dealing with violence, especially sexual violence, every health service has care protocols and mechanisms for referrals to the institutions responsible for resolving these cases. Not all services have post-exposure prophylaxis kits, for which reason cases have to be referred to the Regional Hospital of Boquerón.

With regard to care, follow-up and legal support in cases of violence of any type, as well as addressing human rights and discrimination, only the Regional Women's Centre, CODENI, the Boquerón and municipal governments have protocols and care strategies and staff trained to address this issue. Health services are limited to the initial treatment of cases and subsequent referral to the appropriate bodies.

Of all the institutions, only the Government of Boquerón has a shelter for victims of violence and their families, for which reason the only emergency action for women who do not have this service in their communities is the restriction and exclusion of the aggressor from the residence of the woman and children, which is frequently not implemented, as described in previous sections, due to many women being highly dependent on resources provided by their partners and not having money or food. As they do not have institutional support they find themselves having to go back to their aggressors.

All these actions are aimed at the general population. According to the institutions themselves, they do not have differentiated strategies for indigenous populations; they do, however, identify specific actions for these communities, especially those related to violence, early pregnancy, medical care (especially for those who are pregnant), free HIV and syphilis testing and prevention and treatment of TB.

#### 7.2.1.2 Human resources

All the institutions have technical teams that, depending on the type of institution and its lines of action, have a technical team with various professionals among whom may be mentioned: doctors, nurses, midwives, lawyers, social workers, psychologists, administrators, police officers, volunteers and promoters.

The only institutions that reported having **volunteers** on their technical teams were the Government of Boquerón and the Uje Lhavos Family Health Unit (Filadelfia). As for promoters, only the Cayin O Clim Family Health Unit (Colonia Neuland) said that it had one. The other institutions have paid and/or salaried professionals.

All the institutions said that their staff are being or have been trained in such matters as gender-based violence, sexual and reproductive health, HIV and human rights. As for institutional self-evaluations of the level of training among their human resources, most agreed on a level of "moderately trained" in the different approaches selected in the instrument: human rights, gender, interculturality and intergenerational.

The issue of human rights and gender, however, has been the one receiving the greatest positive evaluation, "very trained", in contrast to the issues of interculturality and intergenerational, where they self-assessed as being between "moderately trained" and "little trained".

While they report that they work with the indigenous population, they do not have protocols or differentiated strategies for an approach with an intercultural appropriateness and perspective. There do exist protocols for care in cases of violence and HIV, but they are the same as those used for everyone or the population in general.

Most of the services offered are of the assistentialist type, oriented towards covering such basic needs as

medical, legal, technical, psychosocial and, especially, educational (more precisely, imparting information and raising awareness) assistance on different issues. No training programmes or projects have been identified, except that of the Regional Women's Centre, which reports having hairdressing, manicure and cookery courses for women. Similarly, no actions were identified for economic empowerment through entrepreneurship projects or microfinance to start up productive businesses, or others.

#### 7.2.1.3 Buildings, infrastructure, material and financial resources

A series of needs has been reported in terms of structures and material resources. Some family health units do not have their own premises and must treat their patients in spaces lent by other institutions that often do not meet minimum comfort and privacy requirements. In addition, there is a clear lack of financial resources for infrastructure improvement - buildings and to pay some staff.

One of the urgent needs, especially for institutions that provide services to the population, is the lack of mobile telephones to access the different communities and reach out with the services, goods and resources that they offer. The Department of Boquerón has the third largest land area and the lowest population density in the country; in other words, its communities, settlements, villages, districts and towns are separated by great distances. This makes it difficult or impossible for people to access institutions and request their services; the other side of this is that services are not able to bring their actions to the communities..

#### 7.2.1.4 Institutional coordination

In general terms, it is noted that the coordinated, joined-together actions reported by institutions are rather at the activity level and there is no evidence of these coming from inter-institutional or intersectoral plans. Actions are piecemeal and there is little participation by other actors.

According to the information provided, the areas with the most coordination and/or joint work at the activity level are the areas of sexual and reproductive health and HIV, followed by violence and little action on human rights.

Regardless of type, every institution in our sample reported that its main counterpart for joint work was state bodies and, in some cases, some universities. No participation or coordination with civil society organizations was identified.

#### 7.2.1.5 Attitudes and motivation to address violence and HIV in indigenous populations, and in women in particular

In general, all the institutions interviewed evinced openness, a good attitude and political will to participate, collaborate in and/or coordinate actions related to the activities of the potential project, "Strengthening integrated services for indigenous women affected by HIV and violence".

It was observed that some activities had greater buy-in by institutions than others.

The activities in the selected indigenous communities that were rated higher in terms of viability by the Department of Boquerón are:

**Activities rated as "very viable"**

1) Organizing workshops for indigenous women, local leaders, health services officials and other stakeholders on HIV, violence against women and the results of the assessment.

3) Developing the capacity of local Government and communities to implement plans, policies and programmes to improve the prevention, care and treatment of HIV and related health services

aimed at indigenous populations, paying special attention to discrimination and the specific needs and rights of women and girls.

9) Conducting joint promotional activities by national and regional stakeholders in order to support similar activities in other indigenous communities.

4) Providing technical assistance to integrate services for victims of violence, foremost among which should be access to justice and health services related to HIV, in collaboration with traditional leaders and Government.

2) Developing an action plan agreed by all stakeholders and based on the barriers and priorities identified, on the data available, on ongoing interventions and best practices.

**Activities rated as "moderately viable" and "barely viable"**

5) Promote non-discriminatory HIV-related services targeted at indigenous women sex workers and their clients and at the indigenous victims of sexual exploitation.

6) Educate indigenous women living with HIV and affected by the disease on human rights, gender issues, HIV and services available, use volunteering techniques.

8) Document lessons learned, best practices and materials to be shared among the four countries and the other countries of the region, using existing volunteer networks in order to reach vast, remote areas.

7) Train local leaders and men and boys on human rights, HIV, gender and masculinity, using volunteer techniques.

### 7.2.2 Institutional response to violence and HIV in the Department of Boquerón and in indigenous populations

Three in-depth interviews were conducted with key stakeholders to gain detailed information on prevention, care and support services for cases of violence and HIV. The person interviewed to gain information on violence was Deisi Jara, of the Regional Women's Centre in the town of Filadelfia and those interviewed for health were Dr José Álvarez of the Family Health Unit of the Uje Lhavos Community and Graduate Nurse Estellita Peña, from the Santa Teresita Family Health Unit.

#### 7.2.2.1 Interviewee on violence

The Regional Women's Centre is under the Ministry of Women and is the main reference point for prevention of gender-based violence, including violence against children and the elderly, as well as for the protection of victims.

One of its main actions is publicizing Law 1600 "Against domestic violence", especially to women so that they know their rights and in this way to promote the habit of reporting offences, through education and information activities. Other activities are prevention and support. They do not have care services; if this need is identified they make the appropriate referrals.

They are currently carrying out a campaign entitled "Courtship without violence" primarily aimed at teenagers and young people.

In relation to indigenous communities and peoples, the Regional Women's Centre works in collaboration with the Indigenous Women of Chaco Platform, mainly on awareness-raising and education activities. It reported that it has the support of community leaders, who have expressed concern about this issue.

The communities with which it is currently working are: Mayeto, Guaraní, Yalve Sanga and Uje Lhavos.

The interviewee said that in the period 2014-2015, the majority of the people attending were women from indigenous communities. Most of the requests made were related to physical and also economic violence, most especially the provision of food by male partners.

In this regard, a serious problem identified is when in confirmed cases of violence the exclusion procedure is performed and there then begins the process of providing food, since most of the women have no income of their own and depend on the resources generated by their partners. When this situation arises and the process of providing food becomes extended, many women give up and are forced to go back to their aggressors.

Many women tell you: "And in the meantime, what are my children going to eat? Where am I going to go?... Some men tell their wives or partners: "I won't pay the rent if you don't come back to me." *(Deisi Jara, Regional Women's Centre)*

One of the main barriers encountered are those women who, because of economic deprivation often have to stop the proceedings they have begun against their attackers and go back to them, since they are the only means of support for them and their children. Compounding the situation, there are no shelters or nurseries in the entire Department of Boquerón where these women could go so as not to be forced to return home and live with their aggressors.

To partially remedy these difficulties, the Regional Women's Centre conducts activities with the goal of improving employment opportunities for women; although they are not productive or resource transfer projects, they are training in such jobs as hairdressing, manicure and cookery (bread and cake making). The purpose of these courses is for women to be able to work from their own homes and generate their own financial resources.

The barriers identified include a lack of financial and material resources, since they do not have sufficient human resources, nor a mobile telephone to facilitate access to the different communities, taking account of the great distances between them; to solve these difficulties, they have developed an agreement with the Departmental Government which provided them with a mobile telephone in order to be able to conduct training.

Barriers have been identified at the cultural level too, especially when indigenous people show negative attitudes to the national legal and regulatory framework or when they seek solutions in internal authorities before turning to public institutions.

"We come and give a talk and collect opinions, because it is good to get to know the culture and opinion they have of what we raised...but we have had some communities that have said "your white law" (on Law 1600 on domestic violence)...we don't want them to change their culture, but both men and women need to know that there is a law that provides protection from domestic violence, and that not everything can be solved by violence". *(Deisi Jara, Regional Women's Centre)*

"The first thing they try is to solve it internally, and if it cannot be resolved it is the leaders themselves who call and provide support for the exclusion procedure and check that it is complied with." *(Deisi Jara, Regional Women's Centre)*

With regard to thematic coordination, the only things addressed together with violence are some aspects related to sexual and reproductive health, especially in cases of sexual violence and the prevention of early pregnancies, as well as content on gender, human rights and non-discrimination. In relation to HIV there is no action at present.

Another barrier identified is the low rate of reporting. Some of them could have been dealt with within the community by pastors and leaders and, therefore, not be referred to public institutions. A workable strategy has been identified, however, to generate reporting, implemented through the training conducted by the Regional Centre in the communities. It has been seen that, on some occasions while some assessment tools are being used in workshops, women write anonymous notes saying that they are experiencing a situation of violence.

"During some surveys they leave you messages: 'I'm going through this.' 'Thank you for this.' 'There are things that I didn't know and it happens to me every day, I just call them nothing special.'...Then, before the workshops end, we leave them our numbers and the phones start ringing...then we go along, confirm the allegation...sometimes we make the complaint ourselves with the consent of the woman...we've worked lots like this." *(Deisi Jara, Regional Women's Centre)*

With regard to the approach to males, the Regional Centre does not have any experience or strategy to address male aggressors. In some cases all that is done is refer them to the Radio ZP30 advice service. There are no professionals to deal with aggressors at the public level either.

Some of the strategies to improve interventions and overcome the barriers identified include: i) Inter-institutional work through liaison committees between the various stakeholders and bodies involved; ii) Promoting the participation of the communities, and especially of women, at every intervention level, from the planning of actions through to their implementation; iii) Promoting joining and participating in the **volunteer** force, especially by members of the indigenous communities with access to communities, that are usually very closed to external institutions.

#### 7.2.2.2 Interviewee on health

EIn the interview, Dr José Álvarez, from the Family Health Unit of the Community of Uje Lhavos, Graduate Nurse Estelita Peña, from the Santa Teresita Family Health Unit[26] and Dr Ivan Vera from the Filadelfia health post[27] identified a series of barriers and good practices that they consider strategic to address to improve prevention, care and support for people affected by HIV in the communities served by the health services for which they are responsible.

One of the main barriers is structural. The Uje Lhavos Family Health Unit is staffed by three doctors, one graduate nurse and a nurse technician, for a population of approximately 6,000 people, more than double the recommended number, since a health service with the characteristics of this one and its number of staff cannot look after a population of more than 2,500 people. The Santa Teresita Family Health Unit has two physicians, one dentist, one doctor of medicine, one graduate nurse, one nurse technician and **one volunteer**. This Family Health Unit uses a Guaraní Women's premises, lent for a certain time. The roof is in poor condition, it has no protection for consultations and does not have basic services such as drinking water or sanitation. The nurses have to return to their homes to go to the bathroom. It does not have any means of transport for emergency cases, only being able to use

26 The Family Health Units are public health services under the Primary Health Care Directorate of the Ministry of Public Health and Social Welfare.

27 The Filadelfia health post is a health service under the Local Health Board of the Municipality of Filadelfia.

private vehicles, and it needs a budget allocation to pay a **voluntary promoter**.

In addition, cultural aspects of the communities that sometimes lead to difficulty in accessing health services and their link with them are perceived as barriers. Firstly, not having indigenous promoters who speak the different communities' languages makes it difficult to ensure participants correctly understand talks and workshops.

"A trainee nurse from the community told me that the people coming to my talks don't understand me...and she told me that we need a health promoter to come with us to translate the talks...we need a trained promoter." *(Dr. Álvarez, Uje Lhavos Family Health Unit).*

Dr Álvarez also identifies that the influence of the churches could have a potential effect on the decisions people make about their health.

"The truth is that it's all run by the church here and with the church's rules; they don't open up much and everything is resolved through the church. They don't let CODENI in, or the Women's Secretariat or the police." *(Dr. Álvarez, Uje Lhavos Family Health Unit).*

This influence of authorities internal to the communities (pastors, leaders and councils) leads in some circumstances to a conflict between the interests of the public institutions that have the mandate to protect the people who are most vulnerable and most exposed to risk and the stance of internal indigenous authorities that opposes interventions by external agents.

"Talking about pregnant 12-year-olds has become normal here...at first we explained to the leaders that this was a social problem and that usually there was always violence behind these cases... they gave me a verbal lashing and told me that it was their problem and they would deal with it and I had no right to call CODENI, the Women's Secretariat and I shouldn't stick my oar in...they told me that if there are problems of this type I need to keep aside...these are matters that they deal with and prevent us from getting involved." *(Dr. Álvarez - Uje Lhavos Family Health Unit).*

"Also, they check up on under-age girls (aged 13 to 16 years)...they check up on them because they go out on to the road at the weekend (sex work), that is, they carry out antenatal checks...nobody says a word. If she gets pregnant it is because it's part of the culture, according to the Manjui." *(Graduate nurse Peña, Santa Teresita Family Health Unit)*

According to the interviewee, the stance against interventions by external institutions reaches the point of taking up violent positions against the "intrusion" of actors from outside the community.

"It's very difficult for them (the police) to get in here; they are attacked even if they come in with the patrol boat." *(Dr. Álvarez - Uje Lhavos Family Health Unit).*

Regarding the attitudes of members of the indigenous communities served by the Uje Lhavos Family Health Unit, Dr Álvarez reported encountering difficulties in providing access and then linking people to the health service.

Up to now, the Uje Lhavos Family Health Unit has detected four confirmed cases of indigenous people

infected with HIV, but Dr Álvarez told us that treating these individuals is challenging, since two of the adult cases "deny" being infected and are not following treatment, and the two other cases are the result of perinatal transmission, where the mother was diagnosed in an antenatal check-up but then did not return for further care and, efforts to contact her again proved fruitless due to her constantly moving home. It was only when the time came for her to deliver that she returned to the health service but it was not then possible to conduct a Caesarean. Meanwhile, the Santa Teresita Family Health Unit has detected some cases of syphilis.

"We try to carry out good checks, we go out to find them, but they are very slippery...they are not aware, or perhaps they are and avoid us." *(Dr. Álvarez - Uje Lhavos Family Health Unit).*

From what has been said above, those interviewed say that it is very difficult for the health services to conduct awareness and prevention campaigns with the indigenous communities. The explanation is that people "do not cooperate", "there is very little social participation" and, sometimes, they do not provide their real contact details, which makes it difficult to monitor them and contact them again if they stop coming to check-ups.

In addition, they do not have materials designed for and suitable for indigenous peoples. Materials and manuals are appropriate for the centre, but not for the communities. There is no cross-cutting interculturality approach in any of the Ministry of Health strategies or materials.

Despite this, alternative strategies have been tried that have had positive results. One of the strategies to motivate people to take part in talks and workshops organized by the health service is to offer them a community meal after the educational activities. This initiative has been successful and many people take part in the activity, motivated by the food that is offered after it.

"They took no notice of us at first, because we didn't offer any food, but now we offer a communal meal or a snack or breakfast and this brings in a good attendance." *(Dr. Álvarez - Uje Lhavos Family Health Unit).*

"We need a bigger budget for the training days, for women and men, because if not nobody pays attention." *(Graduate nurse Peña, Santa Teresita Family Health Unit)*

Another strategy that they are thinking of implementing is the use of non-conventional resources for learning activities; in this case this means using audiovisual media and cinema which, according to the interviewee, draws much attention on the part of the indigenous people.

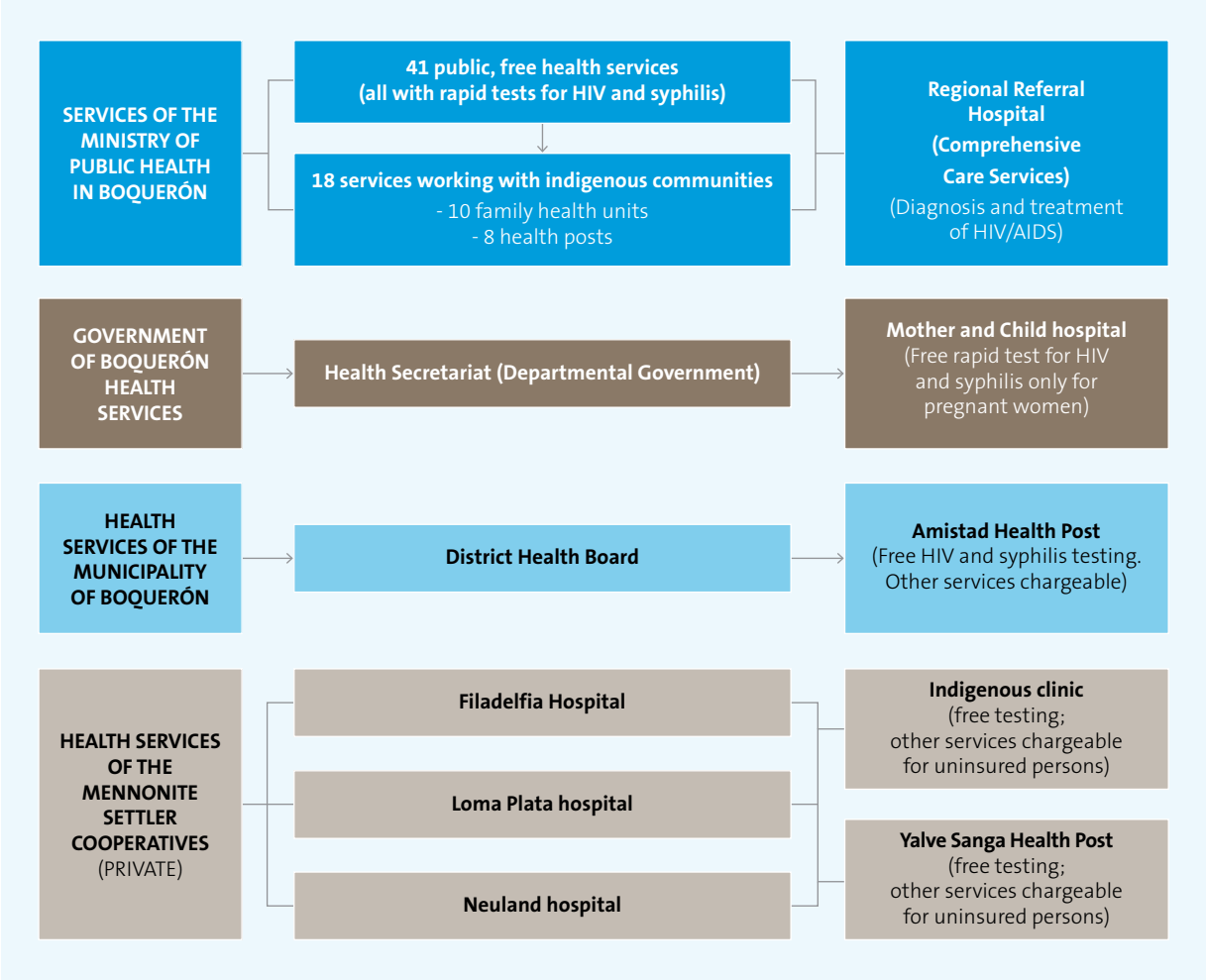
"We are thinking of using film...this is a big draw... with a projector and a computer we can show videos four nights a month, these would be useful." *(Dr. Álvarez - Uje Lhavos Family Health Unit).*

## 7.3 Map of reference actors and institutions on violence and HIV in the Department of Boquerón

### 7.3.1 Health sector

The structure of services in the Department of Boquerón has different sectors and actors. The main provider of health services is the Ministry of Public Health and Social Welfare, which has a network of integrated public services ranging from basic care units, such as the family health units, to the Regional Hospital of Boquerón, located in the town of Filadelfia, which is a more complex general hospital. This hospital is the only service in the whole of the Western Region (Chaco) with an operational Comprehensive Care Service for HIV/

CHART 2




AIDS, providing diagnosis, care and treatment for people living with HIV. It is, therefore, the referral centre for every case of HIV detected by every service, including private, independent, Departmental and municipal.

Having the greatest service coverage, the Ministry of Health is also the main provider of health services to indigenous peoples. For this, it has specific services established near the different communities, which mainly treat indigenous populations. There are a total of 18 health services (10 family health units and eight health posts) that provide care mainly to the indigenous population.

Other sectors, different from the public, that provide care in the Department are the Departmental Government which, through the Secretariat of Health manages the Mother and Child Hospital of Filadelfia and at municipal level the Amistad Health Post. Both of these services are used by large numbers of indigenous people. Like services under the Ministry of Health, these services are free for everyone.

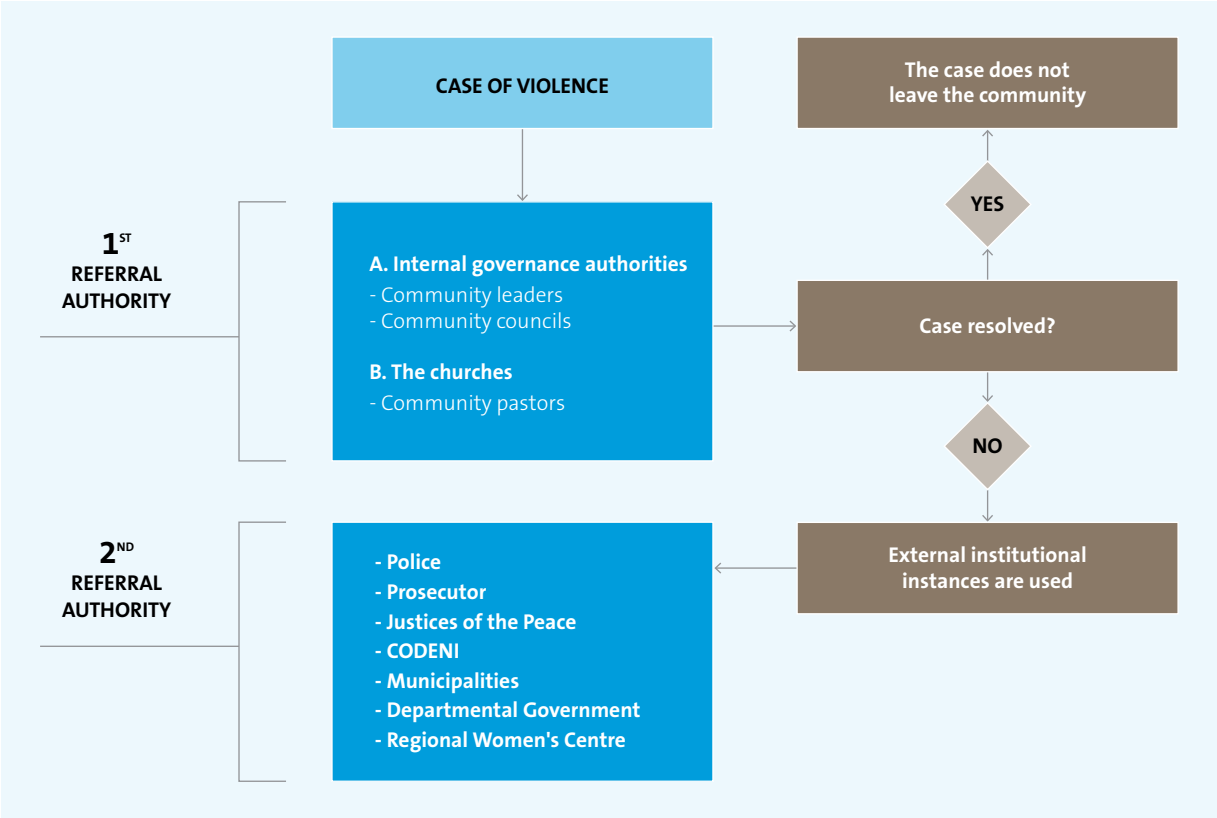
Finally, as a third major service provider there are the hospitals and health posts under the Mennonite settler cooperatives, of which there are three and under which is the sole indigenous clinic in the region. This

indigenous clinic, which is under Filadelfia Hospital, exclusively cares for populations from the different indigenous communities; in spite of the name of the service (indigenous), however, it does not meet the accessibility criteria required by this population, a high percentage of which is mired in extreme poverty: universalization of access and treatment free of charge. As it is a privately-run service, the only people who can access the full range of services are the people (mostly Mennonite settlers) who contribute to the cooperative. Only those indigenous people who are employed by the Mennonites and have to pay 5 per cent of their wages to the social insurance scheme can access services; but even then access is not free since they have to pay a monthly premium. Only services under some Ministerial programmes, especially the sexual and reproductive health, TB and HIV programmes, are free in these services, regardless of one's employment status, under an agreement with the Ministry of Health other services that are not underwritten by the Ministry of Health are chargeable.

### 7.3.2 Response and referral for cases of violence

As described in the Results section, interviewees said that when a case of violence arose that the community perceived as reportable and that needed intervention by some formal authority, the first option was to take it to the legally constituted community authorities, such as the leaders and councils. In addition to this, each community said that they also go to the pastors of the churches for their "advice" and support. Many

**CHART 3**



cases of violence are managed and resolved by these authorities with no need to use external institutions, except for cases that community authorities are not able to resolve or where, due to the seriousness of the case, communication takes place and they are referred to institutions recognized as having capacity to receive allegations, especially the police, the prosecutor, the justices of the peace and, in those places without prosecutors and in cases of violence against children and adolescents, to the CODENIs.

Nevertheless, according to some statements by interviewees, there are some kind of "tacit" agreements between community authorities and public institutions, in the sense that when a case arises that bypasses the community authority and goes directly to an external institution, the case is addressed by "asking" the complainant to firstly try to "resolve" it within the community or, failing that, to come "accompanied" by a leader or member of the Council.

In the case of the Departmental Government, the municipalities and the Regional Women's Centre (under the Ministry of Women), while they are not implementing bodies (such as the police, prosecutor, courts and CODENI, which have the power to enforce the legislation in force on violence), they can process allegations and facilitate referral to the appropriate authorities. These are institutions more aimed at training, guidance, support, referral and follow-up.

## 7.4 Summary table of the context of indigenous communities and people interviewed and the main problems identified by them

**TABLE 13**

| Community | UJ'E LHAVOS-Filadelfia |
|---|---|
| **People** | Nivaclé |
| **Number of families resident** | 1050 (5930 persons) according to previous census. Currently estimated at 7500 people. |
| **Amount of land** | 40 Ha. for which the community has title. |
| **Year of settlement** | Clearance work began in 1995 and some families moved and in 1997 the new community moved in. |
| **Provenance of residents** | San José Esteros, Colonia 22, Fischat San Leonardo, Escalante, Filadelfia. |
| **Services in the community** | • A Basic School operating from preschool to 7th grade.<br>• One Mennonite church.<br>• One Catholic church.<br>• Family health unit (health post). |
| **Organizational structure of community** | • The community has a single leader chosen periodically and by an assembly The current leader is Agustín Juárez.<br>• The community Council has 15 members, all men.<br>• There is a sports committee (men and women).<br>• There is a women's committee focused on health and education (talks for women).<br>• A women artisans' organization.<br>• The assembly is generally held every two years. Decisions are taken in community assemblies. |

| Main employment activities, by gender | |
|---|---|
| Men | Women |
| Masonry, painting, mechanical workshops, carpentry, tractor driver, supermarket employee, service stations (vehicle fuel), and ranch work. | • Domestic employee in homes of Mennonite settlers, waste collection, plastics collection and recycling.<br>• Some single mothers are street vendors.<br>• A group of approximately 15 women have formed a group to make craft items. |

| Main problems for children, adolescents and women identified by residents | |
|---|---|
| **Children** | • Education and school dropout problems on financial grounds.<br>• Extreme poverty, undernutrition, insufficient clothing.<br>• Early take up of alcohol and cigarettes (from 13 years).<br>• Family conflicts "They have no respect for their parents". |
| **Adolescents** | • Difficulties with education - high rate of school dropout.<br>• Early sexual initiation: Forming couples at an early age.<br>• Addiction problems: cigarettes, alcohol (some say that marijuana, drugs and powder are available) and CRACK COCAINE (base paste derived from cocaine, very cheap and highly addictive).<br>• Violence, gang formation (trouble-causing).<br>• Lack of work "They don't want to work". |
| **Adult women** | • Unequal access and pay (e.g. lower wages then men).<br>• Obstacles to participation in decision-making (leadership).<br>• Discrimination by non-indigenous people.<br>• Violence against them by indigenous and non-indigenous people (Brazilian - Mennonite).<br>• Some do street sex work.<br>• Early sexual initiation Early pregnancy Early entry into live-in relationships.<br>• Cases of TB (some) and SYPHILIS (some/many). |

**TABLE 14**

| Community | BETANIA |
|---|---|
| **People** | Nivaclé. |
| **Number of families resident** | 171 (approximately 420 people). |
| **Amount of land** | 700 Ha. for which the community has title. |
| **Year of settlement** | Some say 1927, others 1970. |
| **Provenance of residents** | Pilcomayo area; Mistolar, Pedro Peña, Yalve Sanga, Nish'a toyi'sh, Santa Teresita. |
| **Services in the community** | • Nursery school and from grades 1 to 6.<br>• Just one (Mennonite) church. |
| **Organizational structure of community** | • A single leader and 11 members of the Community Council; all men (includes pastors of the church, sports, health, education, church committee).<br>• A church women's organization: also includes young people, health, education and sports committees. |

| Main employment activities, by gender | |
|---|---|
| Men | Women |
| • Masonry, mechanic, driver, tractor drivers, service stations (vehicle fuel), farms.<br>• On ranches: field clearing, fencing, gardening.<br>• In the communities: agricultural activities. | Working on family vegetable plot, hoeing on the Mennonites' farms, collecting Sesame and beans, horticultural work, craft work, domestic work (Loma Plata, Yalve Sanga, and in the homes of the Mennonite pastors). |
| **Main problems for children, adolescents and women identified by residents** | |
| **Children** | • Education and school dropout problems on financial grounds Schools do not provide lunch.<br>• Extreme poverty, undernutrition, lack of clothes (especially a lack of warm clothes in winter). |
| **Adolescents** | • Educational difficulties: High school dropout due to addictions to alcohol and other drugs.<br>• Early sexual initiation: Forming couples at an early age.<br>• Violence.<br>• Poverty. |
| **Adult women** | • Obstacles to participation in decision-making (leadership).<br>• Discrimination by non-indigenous people.<br>• Violence against them by indigenous people and by institutions (institutional and structural violence).<br>• Early sexual initiation Early pregnancy Early entry into live-in relationships. |

**TABLE 15**

| Community | GUIDAICHAI |
|---|---|
| **People** | Ayoreo. |
| **Number of families resident** | 104 (approximately 4286 people) according to 2013 census. It is estimated that there are currently 130 families settled there. |
| **Amount of land** | 2 Ha. for which the community has title. |
| **Year of settlement** | 2 January 2015. |
| **Provenance of residents** | Campo Loro, Ebetogue, Garay. |
| **Services in the community** | • Lack of basic services: Drinking water has to be bought.<br>• School for grades 1 to 4. It has two teachers (one woman and one man)<br>• **Two churches** (one Mormon and one evangelical). |
| **Organizational structure of community** | • It is not a community. Residents recognize that it is a Neighbourhood. This is what the Filadelfia Town Council says. Nevertheless, they have a representative, not a leader. It is led by the current neighbourhood schoolteacher. It has four councils, one for each street.<br>• There is a women's committee dedicated to craft and various activities. |

| Main employment activities, by gender | |
|---|---|
| Men | Women |
| Masonry, tractor driver and on the ranches (the Ayoreo people do very little land work, or in supermarkets). | • Some do craft work, others as waste collectors and recyclers.<br>• Street sex work.<br>• Domestic employee. |

| Main problems for children, adolescents and women identified by residents | |
|---|---|
| **Children** | • Education and school dropout problems on financial grounds Schools do not provide lunch.<br>• Lack of drugs in health services.<br>• Early take up of "vices": cigarettes and alcohol. |
| **Adolescents** | • High school dropout due to addictions to alcohol and other drugs.<br>• Early sexual initiation, forming couples early and marrying early.<br>• Violence.<br>• Poverty. |
| **Adult women** | • Violence against them by indigenous people (partners) and by institutions (institutional and structural violence).<br>• Early sexual initiation. Early pregnancy. |

**TABLE 16**

| Community | CACIQUE MAYETO |
|---|---|
| **People** | Enlhet Norte. |
| **Number of families resident** | 250 (approximately 1500 people). |
| **Amount of land** | 2 Ha. for which the community has title. |
| **Year of settlement** | No information. |
| **Provenance of residents** | Locals, some from the Puerto Casado area. |
| **Services in the community** | • It has basic services: drinking water and an electricity supply.<br>• It has a Basic School covering from preschool to 7th grade<br>• School for 8th to 9th grade.<br>• Health post.<br>• FM community radio.<br>• Office for Council members.<br>• An evangelical church.<br>• Community sports ground. |
| **Organizational structure of community** | • One main leader.<br>• One community Council with female and male members.<br>• It has a church women's committee and sports, health and education committees.<br>• There is no set term, in line with a decision by the residents or the main leader. If it does not work they change and the councils convene the Assembly. |

| Main employment activities, by gender | |
|---|---|
| Men | Women |
| Masonry, tractor driver and on the ranches (the Ayoreo people do very little land work, or in supermarkets). | • Some do craft work, others as waste collectors and recyclers.<br>• Sex work: Street sex work.<br>• Domestic employee. |
| **Main problems for children, adolescents and women identified by residents** | |
| **Children** | • Education and school dropout problems on financial grounds. Schools do not provide lunch. |
| **Adolescents** | • High school dropout due to addictions to alcohol and other drugs.<br>• Early sexual initiation, forming couples early and marrying early.<br>• Early take up and high consumption of cigarettes and alcohol.<br>• Violence: abuse of fathers and mothers.<br>• Poverty. |
| **Adult women** | • Violence against them by indigenous people (partners).<br>• Little participation in decision-making.<br>• Early sexual initiation Early pregnancy. |

**TABLE 17**

| Community | CAYIM O CLIM-NEULAND |
|---|---|
| **People** | Nivaclé. |
| **Number of families resident** | 535 (approximately 2600 people). |
| **Amount of land** | 281 Ha. |
| **Year of settlement** | 1954. |
| **Provenance of residents** | Pedro P. Peña, San José Esteros, Escalante. |
| **Services in the community** | • A school covering grades 1 to 7. A school for grades 8 and 9.<br>• An indigenous health post and a Family Health Unit.<br>• Water, a community office a community radio station, a community sports ground.<br>• One Catholic, one Mormon and one evangelical church. |
| **Organizational structure of community** | • It has two leaders recognized by the Paraguayan Institute for Indigenous People (INDI, from the Spanish): A main leader and a vice-leader. Elected by the Assembly in accordance with the decision of the community.<br>• It has a community Council with male and female members.<br>• Administrative Council - adviser (Mennonite).<br>• The community has several committees: sports, environment and education.<br>• It has health promoters. |

| Main employment activities, by gender | |
|---|---|
| Men | Women |
| Masonry, tractor driver, various jobs at Neuland Cooperative, service stations (vehicle fuel), jobs in some large grocery shops, mechanics in Mennonite colony workshop and tyre shop. | • Domestic employee in homes of Mennonites and church pastors.<br>• Supermarket work.<br>• Cleaning work in Concordia Hospital.<br>• Waste collection.<br>• Sex work. |

| Main problems for children, adolescents and women identified by residents | |
|---|---|
| **Children** | • Education and school dropout problems on financial grounds. Schools do not provide lunch. |
| **Adolescents** | • High school dropout due to addictions to alcohol and other drugs.<br>• Early sexual initiation, forming couples early and marrying early.<br>• Early take up and high consumption of cigarettes, alcohol and other drugs (crack).<br>• Violence: abuse of fathers and mothers.<br>• Poverty.<br>• Syphilis. |
| **Adult women** | • Domestic violence by partners.<br>• Lack of economic resources (abused women are forced by economic dependency to return to their partners).<br>• Little participation in decision-making.<br>• Early sexual initiation Early pregnancy.<br>• Syphilis. |

**TABLE 18**

| Community | YALVE SANGA-NEULAND |
|---|---|
| **People** | Enlhet. |
| **Number of families resident** | 837. |
| **Amount of land** | 5,832 Ha. |
| **Year of settlement** | 1932. |
| **Provenance of residents** | Campo Loa. |
| **Services in the community** | • Basic services: drinking water and an electricity supply.<br>• Indigenous clinic.<br>• Community cooperative.<br>• Church (Mennonite).<br>• **School**: grades 1 to 7.<br>• School: 8th grade to 3rd grade of middle education.<br>• Agricultural school.<br>• Boarding school.<br>• Community sports ground. |

| | |
|---|---|
| **Organizational structure of community** | • One main leader who leads all the communities of Yalve Sanga (Robustiano Alemán).<br>• It has a community Council with male and female members, and church pastors.<br>• Women's committees: church, craft work and community work. |
| **Main employment activities, by gender** | |
| Men | Women |
| Masonry, tractor driver, service stations (vehicle fuel), work in large grocery shops, mechanics in Mennonite colony workshop and tyre shop. | • Domestic employee in homes of Mennonites and church pastors.<br>• Supermarket work. |
| **Main problems for children, adolescents and women identified by residents** | |
| **Children** | • Education and school dropout problems on financial grounds. Schools do not provide lunch.<br>• Mild and serious respiratory and gastrointestinal diseases. |
| **Adolescents** | • High school dropout due to addictions to alcohol and other drugs.<br>• Early sexual initiation. Forming couples and marrying early.<br>• Early pregnancy.<br>• Early take up and high consumption of cigarettes, alcohol and other drugs (crack).<br>• Violence: abuse of fathers and mothers.<br>• Poverty.<br>• Syphilis. |
| **Adult women** | • Domestic violence by partners.<br>• Lack of economic resources (abused women are forced by economic dependency to return to their partners).<br>• Little participation in decision-making.<br>• Early sexual initiation Early pregnancy.<br>• Syphilis. |

**TABLE 19**

| Community | YALVE SANGA-EFESO |
|---|---|
| **People** | Enlhet. |
| **Number of families resident** | 837. |
| **Amount of land** | 5,832 Ha. |
| **Year of settlement** | 1932. |
| **Provenance of residents** | Campo Loa. |

| | |
|---|---|
| **Services in the community** | • Basic services: drinking water and an electricity supply.<br>• Indigenous clinic.<br>• Community cooperative.<br>• Church (Mennonite).<br>• **School**: grades 1 to 7.<br>• School: 8th grade to 3rd grade of middle education.<br>• Agricultural school.<br>• Boarding school.<br>• Community sports ground. |
| **Organizational structure of community** | • One main leader who leads all the communities of Yalve Sanga (Robustiano Alemán).<br>• It has a community Council with male and female members, and church pastors.<br>• Women's committees: church, craft work and community work. |
| **Main employment activities, by gender** | |
| Men | Women |
| Masonry, tractor driver, service stations (vehicle fuel), work in large grocery shops, mechanics in Mennonite colony workshop and tyre shop. | • Domestic employee in homes of Mennonites and church pastors.<br>• Supermarket work. |
| **Main problems for children, adolescents and women identified by residents** | |
| **Children** | • Education and school dropout problems on financial grounds. Schools do not provide lunch.<br>• Mild and serious respiratory and gastrointestinal diseases. |
| **Adolescents** | • High school dropout due to addictions to alcohol and other drugs.<br>• Early sexual initiation, forming couples early and marrying early.<br>• Early pregnancy.<br>• Early take up and high consumption of cigarettes, alcohol and other drugs (crack).<br>• Violence: abuse of fathers and mothers.<br>• Poverty.<br>• Syphilis. |
| **Adult women** | • Domestic violence by partners.<br>• Lack of economic resources (abused women are forced by economic dependency to return to their partners).<br>• Little participation in decision-making.<br>• Early sexual initiation Early pregnancy<br>• Syphilis |

## 7.5 Conclusions and recommendations: Gaps, good practices and opportunities for work

After triangulating the different sources of information (indigenous populations, institutional contact people on violence and health and the research team made up of some indigenous interviewers and every interviewer having considerable knowledge of the study communities), a series of strengths and opportunities has been identified that together would be facilitating factors for implementation of actions to improve the institutional response to violence and HIV. In addition, weaknesses and threats have also been identified that must be taken into account when

planning interventions, since these factors constitute a programme risk that would determine the viability and effectiveness of actions.

For this we used a SWOT (strengths, weaknesses, opportunities, threats) analysis to describe the internal and external scenarios to enable us to identify the positive aspects that must be maintained and strengthened and the debilitating aspects that must be minimized in order to develop a plan/programme/project/strategy to achieve the results planned for.

The factors identified fall into logical levels: i) the individual and collective level of women as political actors and holders of rights based on their beliefs, knowledge, attitudes and practices; ii) an intermediate community level that explores the organization of power and access to the various services; and iii) an institutional response level that explores the capacity of public institutions to respond to HIV and violence and their degree of coordination and organized work.

These factors have the property of being in different fields of the scenario analysis, that is, they are both strengths and weaknesses, and opportunities and threats.

For this analysis the interviews with the different key informants (indigenous people and institutional actors) were taken as inputs and the development of conclusions and recommendations was conducted collectively with the research team.

### 7.5.1 Conception, perception and particular attitude related to the phenomenon and scope of the concept of violence and aspects related to HIV as a starting point for women's empowerment

**Strengths and opportunities:** The perception of violence in the indigenous communities interviewed oscillates between the objective (specific situations) and the subjective (situations experienced internally and not always observable). The objective situations are situational, with specific triggers and visible, measurable consequences. That is, violence is any act that is caused by a known factor (alcohol, lack of money, infidelity) the purpose of which is to do objective, visible and/or felt harm (wounds, sequelae, pain, suffering, or unhappiness).

The main types of violence are recognized: physical, psychological and sexual. In a small number of cases they also recognize economic violence.

In addition, the notion of violence as a disturbance or wounding of the "being" and "spirit" has also been identified in the statements analysed. This type of violence has no apparent immediate or visible consequence or sequela but it leads to great suffering, imbalance, disturbance and unhappiness in the respondents, especially in women and young people.

Most people know about the authorities for the submission of allegations, both internal and external, and they use them in line with their assessment of each case in hand.

Every group evidenced knowledge of HIV (an incurable, chronic infectious disease caused by a virus). They also correctly identify its means of transmission (mainly sexual) and means of prevention (abstinence, mutual fidelity and condom use). In relation to the risk factors identified, they recognize factors linked to sexual behaviours (multiple sexual partners, early sexual initiation, non-use of the condom, sex work, sex with persons of the same sex).

It is a good starting point to have correct information on issues related to HIV, but this is not sufficient to motivate behaviour change and the adoption of protective behaviours.

**Weaknesses and threats:** Other types of violence that are not so obviously recognizable or immediately severe are not considered as violence. Structural or symbolic violence, as it does not have such obvious consequences, is culturally normalized and/or legitimized (as in early sexual relations or marriage).

There are also "blind spots" when reflecting on the causes or risk factors for violence. Only immediate factors are considered, such as high alcohol or drug consumption, lack of economic resources, jealousy and infidelity, among others.

There is a perception of the notion of "causes of causes", that is, distal factors that create the scenarios of vulnerability that are conducive to violence, such as gender, age, poverty, inequality of opportunities, loss of living space and land, forced migration to urban centres, institutional violence, discrimination, etc.

These latter social determinants, even if they are not well spelled out directly, are perceived as factors that relate to violence in all its manifestations.

They talk about problems of access to land, this leading to overcrowding in urban areas, in turn leading to an atmosphere of aggression (alcoholism, gambling, sexual abuse, etc.) Those interviewed are aware of the root and distal causes of violence. They refer to the fact of being women and of trying to resolve problems with authorities that pay more attention to men. This indicates that there is a degree of awareness of this gender factor (albeit not expressed in technically correct words or phrases).

Most, though they expressed it differently, experience institutional violence, especially in health posts where they are not treated, being excluded through belonging to areas covered by the Mennonites where they have the insurance scheme. In addition, they also consider it an act of exclusion (violence) that the institutions do not have promoters/volunteers from the communities to enable communication in their native tongue and understanding of content that is often technical and complex.

The perception of and attitude towards violence is not a minor or merely technical issue, since this world view of violence determines people's behaviour and decision-making in relation to the phenomenon perceived.

As with the perception of violence, people clearly identify the predisposing factors to HIV infection. Even so, their analysis ends at an acknowledgement of the most immediate and evident factors, especially those related to sexual behaviour. This notion of risk focuses on individual behaviour and responsibility, that is, someone is infected with HIV because "of something they've done", since it is their individual responsibility. There is no perception of reflection beyond this level, such as making a link with other determinants such as poverty, gender or ethnicity.

While HIV is perceived as a threat, it is also considered as something "external", something of "others", and this perception may distort perceptions of individual and collective risk.

In spite of having correct information on HIV and its means of prevention and transmission, this is not reflected in preventive behaviours. High consumption of alcohol in the male population, especially younger men, early sexual initiation legitimized by cultural reasons and the perception of HIV as something distant and external (HIV is a disease of "others", foreigners and Paraguayans, and not indigenous people) focused on "at-risk groups" such as mainly MSM and women sex workers leads to a distorted perception of risk that influences correct decision-making. Good risk management involves a clear perception of the threat of HIV and the assessment of the group itself as vulnerable to HIV through a correct identification of the associated risk factors.

The risk of HIV is related to "individual" behaviours, that is, responsibility is personal and there is no perception or awareness of structural, political, economic and social factors that affect some people when making decisions, since these factors create inequality and individuals' ability to control their social determinants and risk factors decreases, exposing them to increased vulnerability.

**Recommendations:** This latest, more contextual and structural analysis of violence and vulnerability to HIV has been described by the research team on the basis of accounts given by interviewees. Even if the relationship between poverty, gender, ethnicity and violence is clear to the team, this level of reflection is not always found explicitly expressed in the accounts of indigenous people.

The communities that were interviewed are mostly settled in the urban centre and are exposed to different processes of exclusion and discrimination, mainly based on extreme poverty cross cut by other variables such as gender and ethnicity.

In this regard, it is of fundamental importance to create spaces for analysis and reflection at community level to enable people to recognize the existence of distal factors that are not always visible but that generate and maintain processes of exclusion and subordination of indigenous peoples.

The empowerment process begins when people in vulnerable situations identify and recognize the social determinants that reduce their power to exercise control over their risk factors, in order to take control of them. Especially in women, recognizing that gender, social class and ethnicity are variables that together exert control over their decision-making processes in favour of dominant groups and perpetuate this dependence is a fundamental step to begin a process of empowerment and participation in decision-making both within communities and at the level of public policies of the State.

A series of assumptions that must be taken into consideration when developing empowerment strategies for indigenous women has been identified:

- The need to construct an alternative political space. Power is built collectively.

- Seizing power through organization and participation involves generating changes within indigenous organizations. The exercise of traditional power through leaders and councils, mostly made up of men, requires a shift towards more horizontal, participatory and democratic practices. Women have a fundamental role in this process.

- Leadership must be well developed from and for women as an alternative way of exercising power.

- Women's participation must be strengthened first within communities to then take over a public space where political and cultural changes are generated.

- For women to exercise this role (leadership, through participation and the exercise of power) they first need to be made aware and empowered on the basis of their cultural identities, respecting their origins and characteristics. The identities of indigenous women need to be revitalized.

- Taking and exercising power is not achieved through a process of individual empowerment nor through single examples of leadership, but, taking account of a vision of the "collective" held from one's identity as a woman and indigenous person, one must start from this premise. Indigenous women construct their power from the collective with other women and coordination is a fundamental process for this.

- Training is an urgent requirement. Women cannot demand their rights if they do not know what their rights are. The notion of "person with rights and obligations" is constructed from knowledge of rights and their subsequent exercise. Training should be focused not only on generating information and skills, but also on building political actors with power of decision, thus developing valid interlocutors for dealing with decision makers both within communities and with public institutions.

- Spaces for women's meeting, dialogue and reflection must be provided and promoted, with follow-up by sensitive institutions trained in an intercultural approach and delivering content related to power,

participation, leadership and decision-making. In this regard, the role and participation in this process of the Articulation of Indigenous Women of Paraguay (MIPY, from the Spanish) is essential, as the first network of indigenous women from different peoples organized with the aim of influencing public policy and the empowerment of indigenous women.

- Ensure provision of material, financial and human resources by the State and cooperation agencies for the empowerment, participation and leadership process to be viable.

### 7.5.2 Access to and demand for health services and services related to violence by indigenous women and young people

**Strengths and opportunities:** All respondents, regardless of gender and age group, were able to correctly identify the bodies for help and support in the event of violence or exposure to HIV, both within and external to the community.

Internally, the main resolving body for cases of violence are the organs of community Government (leaders and councils) and, in some cases, the church. Nonetheless, they recognize other external bodies such as the police, the prosecutor and CODENI, among others, as institutional sources of help and support.

With regard to HIV, unlike violence for which the main resolving body is within the community, people interviewed clearly recognize the health system (State, Departmental, municipal and private) as the main source of consultation, support, treatment and referral.

One factor that is viewed positively and that generates a greater degree of confidence towards health services, unlike the institutions responsible for addressing violence, is that these services have members of the communities working as officials, promoters and/or volunteers. As these service providers are peers, they are able to access and address communities and people asking for different health services, not only in their language but also with cultural appropriateness due to their having the same characteristics as the officials in question. These people are an important link between the institutions (here, health services) and indigenous populations.

Prevention (condom) and family planning methods (modern methods such as the pill and injections) are known to respondents, who know about the sources of access to them (public and private health services). It has been identified that women positively view and extensively use modern methods of family planning. It is also reported that decisions on sexual and reproductive health are jointly made with partners in many cases.

Prevention and family planning supplies are available free of charge in health services.

A range of sources of information on health and HIV are identified depending on the age of the respondent. Adults see health services, some community radio stations and the churches in some cases as valid sources of information. Among adolescents and younger people, educational institutions and teachers are identified as the main sources of information, enjoying the confidence of students.

With regard to participation in training processes, every group said that it had taken part at least once in activities of this type, mainly organized by the health services and other Departmental and municipal bodies.

There are trained professionals who enjoy the trust of the communities as they are seen as authorities on the subject.

Indigenous nursing technicians, health promoters and volunteers who actively work with some health services have also been identified. This facilitates the

access and involvement of indigenous women, especially in health services.

**Weaknesses and threats:** The organs of internal Government (pastors, leader and Council) are perceived to have a great influence, reinforced by other factors including the little or no trust of the indigenous populations in institutions of the State, especially those working in the area of violence (police, prosecutor, courts, CODENI, etc.).

People perceive these institutions as being disconnected from their interests and reality. Their instruments (laws and regulations) are perceived as being contrary to some aspects of their culture and tradition (some call them "white law", alluding to them being applicable only to non-indigenous people).

This negative attitude would also be reinforced by the lack of participation and involvement of the communities in the processes of construction, execution and validation of public policies that meet their particular needs.

In addition, and unlike the health sector, the public institutions dealing with the issue of violence do not have among their human resources members of the indigenous communities as promoters or volunteers to make first approaches, links, connections and referrals of cases of violence identified within the communities.

Neither do they have differentiated protocols or strategies with an appropriate cultural approach. The conception of violence and its extent, as described above, is not always the same in indigenous cultures as it is in the rest of the Paraguayan population and this perception is not always reflected in national rules and legislation.

In relation to HIV, the main barrier identified is the low rate of condom use, mainly by men. There are beliefs associated with the use of the condom that generate negative attitudes ("condoms may break" or "condoms can be left behind inside the woman"). Other explanations could be that the condom, as a method of prevention, is not culturally adapted to the sex practices of the peoples studied and, furthermore, the influence of the churches within the communities could also be a relevant factor. The churches promote alternative methods to the condom to prevent HIV and unwanted pregnancy. Finally, on top of these barriers there is the difficulty that men, and especially young men, have in accessing supplies for prevention, unlike women, who attend health services more regularly, which facilitates access to modern methods of family planning. According to statements made in interviews with young people, even when condoms are available in health services, neither men nor women tend to ask for them as, respondents say, they would be "embarrassed". In this regard, cultural aspects form major barriers to access certain supplies and services, even above other barriers to access such as availability of the supply or geographical barriers. Even were services to be accessible and culturally appropriate and supplies available free of charge and in sufficient quality and quantity, this would not necessarily increase demand for them if other cultural barriers were not addressed first.

Related to the preceding paragraph, access to health services in general and participation in information-giving and education activities in particular would depend on cultural aspects and, more specifically, on gender issues. Respondents say that responsibility both for the prevention of HIV and for family planning mainly falls to women and men are not involved in these activities. Education session are usually mostly attended by women, with very little participation by males. This is also reflected in demand for health services, where the access gap in relation to women remains significant. Although there are no statistics disaggregated by ethnic group, at national level only 20 per cent of demand for HTC (voluntary HIV testing and counselling) is from men, that is, of every 10 people accessing an HIV test, only two are men and the other eight are women (PRONASIDA, 2013).

Finally, another important barrier related to access to and demand for health services and services related to violence is the maltreatment and discrimination that many indigenous people report having suffered in different public institutions. While the health service is perceived as being "friendlier" to indigenous people, due to there being members of the communities on the staff of the services and also to having some exclusive services such as indigenous clinics, abuse is still reported. In some cases this facility described above (having indigenous clinics) becomes a barrier since, as has been reported, some health officials "invite" indigenous persons (attending some public services) to use "their clinics" (that is, clinics for indigenous people), an attitude with a clearly segregationalist bias. This type of attitude can be more clearly seen in public institutions working on the issue of violence (police, Departmental Government, municipality, prosecutor, CODENI, etc.).

It has been described in this study how some women interviewed said that their allegations were not taken account of in some institutions and officials asked the complainant to come back with the "authorization" of their leader to make the report or, failing that, to come back "accompanied" by their leader. This type of approach could be taken as misogynistic, racist and classist since an allegation made by an indigenous women is worth less if she is on her own, while it has greater value if she is accompanied by the "authorization" of a man, in this case the leader of the community.

Attitudes and behaviour of this kind cause distrust in many people and a considerable lack of trust in public institutions, giving them little motivation to approach them, mainly in cases of violence. As a result, situations of violence tend to be referred to the leader and Council and the level of action remains in an internal, domestic space.

**Recommendations:** What has been achieved in the health sector through the involvement of local indigenous people in the health services as officials, promoters and volunteers is a good practice that could be replicated for institutions to address violence.

No institution working directly or indirectly on violence has human resources from the indigenous communities. Such institutions as Departmental Government, municipality, police, prosecutor and others do not have capacity to reach out to or involve the indigenous persons who may demand their services, indeed the only mediators are the leaders and councils who have the power in the end to decide which cases to refer and which not.

In this regard it is strategic to form a group of indigenous contact people and integrate them into the institutions mentioned as mediators and access facilitators for people affected by violence. These institutions, as described, are perceived as distant from the interests and needs of the indigenous people and, added to experiences of abuse and discrimination, this means that they are viewed with great mistrust and as having little power to resolve matters.

Having indigenous officials, legal promoters, and **volunteers** trained in human rights, gender, childhood and adolescence and with good knowledge of the existing legal framework could be a facilitating factor to develop a relationship of trust between people and their institutions and in this way to facilitate access along a twin track, on one side for people towards the institutions and on the other by having the public institutions access the communities through outreach work by the staff mentioned, working as liaison officers.

In addition, it has to be taken into account that not only are access and demand for services related to discrimination and the availability of supplies, but the cultural aspect is fundamental too, since this generates guidelines for behaviour in relation to demand for health services. In this regard, a gap has been observed in access to health services mainly by men and younger men in particular. There are no strategies for promoting health services or addressing male adults, teenagers or young people in a way that takes

account of their needs when they do access services. In regard to their structure and operation, health services are traditionally focused on mother and child health.

In relation to strategies and care protocols for violence, there are no strategies identified at the institutional level specifically for male aggressors. Violence is an integral phenomenon that involves work with the parties involved and their setting. To address only the victim without including the family, the community and, principally, the male in this process has its limits in terms of the success of such interventions.

On account of all the above, the following lines of strategic action are established:

- Identify, select and train contact persons from the indigenous communities to integrate them into the different institutions working on the issue of violence. Extend this work in the health sector.

- Conduct advocacy work with Departmental and national authorities to ensure financial resources to recruit staff from the communities and thus ensure their formal incorporation into the institutions. Volunteer work should be promoted; however, this work cannot replace the role and functions of the institutions. Volunteering is an important complement that fulfils specific functions, especially in relation to the involvement of communities in the processes of planning, implementing and evaluating actions. Communities need to perceive that they are part of the decision-making process and thus take ownership of initiatives. It is only in this way that the sustainability of initiatives can be guaranteed.

- Develop a process of cultural adaptation for action taken by and from the institutions. As seen, indigenous peoples' beliefs, attitudes and perceptions of violence and HIV are particular, and these particularities need to be incorporated into any strategy to address violence and HIV for there to be an impact on people, respecting their cultural identities and, as far as possible, in their mother tongue. Without this, indigenous people will continue to view institutional actions as being foreign to their reality.

- Develop strategies that address gender and age differences to increase demand for health services in particular. There must be a particular focus on access for men and adolescents. Men must be involved in any decision-making process related to women's sexual and reproductive health and HIV prevention. In spite of having information on prevention materials, many women have no control over them since their partners often make decisions in this area (not using condoms and opposing family planning methods). Health services should identify appropriate measures to involve men in decision-making in conjunction with women.

- Conduct a study on indigenous peoples' attitudes towards the condom as a means of prevention and, on the basis of its results, design strategies to improve principally young people's acceptance of this preventive device.

- Train and raise the awareness of officials and service providers about issues related to the human rights and interculturality approach. There is a regulatory and legal framework that must be followed by public institutions. Develop mechanisms for inspecting, monitoring and following up the quality of care and user satisfaction.

### 7.5.3 Strengthening and democratization of formal decision-making bodies within communities (leaders and councils)

**Strengths and opportunities:** As mentioned throughout the presentation of results, the governing bodies internal to communities (leaders and councils) fulfil a key fundamental role in the organizational life of communities.

As decision-making bodies with great power to rule on various issues, their very existence and operation is an opportunity that, used wisely, would make it possible to secure changes and progress on violence and exposure to HIV.

It is a platform of political organization and governance elected by assembly that is needed for indigenous communities to have representation before external political bodies and is also necessary to secure spaces for dialogue and decision-making at the internal level.

It is also important to take account of the influence exerted by the churches in some communities, which places them as key actors and important opinion leaders. This could be configured as a partner or a barrier that would influence or even prevent the development comprehensive strategies to combat violence and decision-making in relation to the prevention of HIV.

**Weaknesses and threats:** Leaders and councils are the first bodies for resolving conflicts within the communities, including acts of violence. They are closed bodies that do not permit the participation of external actors or State institutions working on the issue of violence. Reports are made subject to the decisions of the leader and Council, who decide which cases are referred to institutional bodies (police, prosecutor, CODENI, etc.) and which are not.

In addition, these bodies do not have a specific or defined approach to cases of violence and it seems that the approach is according to each particular case. Even so, regardless of the type of situation of violence, the strategy to solve it tends towards maintaining and preserving the "link" between the aggressor and victim. This approach would conflict with the measures for immediate protection established in the legal framework on gender-based violence that seek to preserve the life and physical and psychological welfare of the victim above the relationship between the parties involved.

On some occasions, the interests of the leader and Council may not be in harmony with the interests of the community in general and even less so with the particular needs, demands and claims of particular groups, especially women, young people and adolescents, groups that are not seen as important stakeholders in community-level decision-making.

The structures of these organs of internal governance have a strong male bias since they are mostly made up of adult men. Indeed, some women have made it clear that their rights are far from guaranteed in these vertically structured bodies where power is mainly concentrated in the hands of men.

Some interviewees say that while women are members of some councils and also form committees, these are not strong and they do not have meaningful participation in decision-making within these councils.

Returning to the role of the churches, on some occasions the first authority that many indigenous people, especially women, turn to in the event of violence is the community pastor, even over the leader or Council.

The approach by the church is not clear and does not follow an established protocol. Its actions seem to be limited to giving the victim and aggressor "advice" and giving spiritual support. It has been identified that in most cases the objective of these interventions is to preserve the link and family of those involved, which is behind the practice of the victim remaining linked to her aggressor and even in the same house.

In relation to the prevention of HIV, the health service providers interviewed clearly identified the intervention of the pastors as a barrier, and especially their influence on women's decision-making. Condom use is not viewed positively and further than that, the non-use of condoms may be advocated, say health officials.

**Recommendations:** This section is closely linked with the recommendations on participation, coordination

and empowerment of women. That section described how women need to access the exercise of power through organization and empowerment, processes that begin with increased participation in decision-making within their communities. As described in this study, while women's organizations do exist, they do not have political aims but are welfare focused, with little relevance in community decision-making, even when these councils have women members.

There is great power concentrated in the leader and Council on decisions that affect the entire community, but these decisions often do not reflect the entirety of the needs and interests of many groups, especially women and adolescents. In this regard, many women see the need to construct a valid alternative for the exercise and practice of power through their active participation. Young people in turn are also demanding greater spaces for participation and for their voices to be taken into account by leaders and councils.

The study has seen ambiguous attitudes regarding the roles of councils and the types of leaderships of their representatives. On the one hand, there are people who accept this organization of power as part of the autonomy of the community and as a way of preserving themselves from the "external" threat of "white" institutions, while on the other hand, dissident voices increasingly denounce and call for changes within these structures that they often perceive as linked to external political and economic interests (some people identify the economic interests of the leaders with certain business groups and party politicians).

In general, the existence of these instances of power and governance is not questioned; in fact, they are seen as necessary. They do, however, question their role and operation and, above all, their biased, verticalist and undemocratic decisions.

For all these reasons the following lines of intervention are identified:

- Strengthen existing women's networks and orient their activities towards goals of political participation and greater involvement in community decision-making. In communities where no groups of this type exist, promote their formation.

- Identify, train and empower women community leaders chosen from among their companions as focal points for each community, with the authority to represent the women of their communities in different spaces. Train them in the conceptual and procedural tools needed to negotiate with organs of power and influence decisions to the benefit of women.

- Create women's committees with influence on the community Council and give them the power and authority to decide on their procedures of governance and election of their representatives to the Council.

- Advocate for amendment of the by-laws governing the operation of councils and the functions of leaders, with the goal of their properly reflecting all the interests of the different groups (women, young people, adolescents, children and the elderly) that make up the community and which are not represented in these organs of power.

- Promote spaces for inter-ethnic exchange of experiences among women from different peoples and communities with the goal of establishing common agendas and coordinated actions.

- Promote spaces for dialogue and reflection among indigenous adolescents and young people, using participative and experiential techniques. The participation of young people in community decision-making is a goal in itself, taking account of the fact that they are the main group involved in many of the problems identified that are related to violence, HIV and reproductive health, but they do not have a voice of their own before those responsible for making decisions.

### 7.5.4 Institutional response to violence and HIV at Department and local level

**Strengths and opportunities:** There are bodies with different capacities of response and staff trained on the issue. They have the mandate to address every form of violence through protocols and strategies already established by the regulatory and legal framework in force.

Instances of local Government (Department and municipalities) and central-level bodies (Regional Women's Centre, under the Ministry of Women) conduct awareness-raising and education activities in women, adolescents and older people with a human rights and gender approach.

In some cases a degree of coordination has been noted at the activity level. For example, if the Regional Women's Centre is conducting a workshop in a distant area, the Department supports with logistics and means of transport.

There are committed staff trained in gender, violence and human rights.

In general, all the institutions interviewed evinced openness, a good attitude and political will to participate, collaborate in and/or coordinate actions related to the activities of the potential project, "Strengthening integrated services for indigenous women affected by HIV and violence". They viewed the incorporation of volunteers from members of the indigenous communities very positively as a valid and effective strategy for working with this population.

As for the institutional response to HIV, it is here that most work has been done, remembering that there are more resources dedicated to health than there are for institutions addressing violence.

There is an integrated network of health services from the simplest levels of care to those of high complexity.

The existence of services financed by private sources and working with the indigenous population is also valued; an example of this is the Filadelfia indigenous clinic, a service exclusively financed and managed by the Mennonite settler cooperatives

Regardless of the financing system of services (public, Departmental, municipal, private, or a combination of these), they all have agreements with the Ministry of Public Health, enabling some Ministerial programmes to be offered free of charge from these services. This is the case for sexual and reproductive health and HIV programmes, among others. All these services offer HIV and syphilis testing free of charge.

Persons with a positive HIV diagnosis are referred to the Regional Hospital for treatment.

Another positive aspect and good practice described above is the incorporation of indigenous people in health services; there are some nursing technicians and health promoters working in some services who are links with the communities.

In addition, health services also systematically offer information and education activities on issues related to HIV. Despite some difficulties in convening them and securing participation, health care providers have been able to try alternative strategies to facilitate people's attending and staying in these talks. This reflects to a certain extent the interest and commitment of some health informants to the needs of indigenous peoples, aspects that must be reinforced.

National and Departmental institutions report having statistical data on cases of violence obtained through notifying bodies (police, health services, prosecutor, justices of the peace, etc.) and on HIV testing and confirmed cases. For both of these there are standardized notification instruments, referral flow charts and action protocols.

**Weaknesses and threats:** Institutional response capacity is conditional upon the collaboration of indigenous leaders and community councils. In general, their participation in cases of violence is prohibited by a no external intervention policy imposed by the authorities of the indigenous communities. This prevents them from comprehensively addressing cases of violence within the communities using established intervention protocols (allegation, verification, exclusion of aggressor and/or restriction on approaching the victim, protection, support for and monitoring of the victim).

In addition, there are occasions when they do not accept allegations from indigenous people if they are not accompanied by the leader's "authorization" or by the leader in person.

It has also been reported that, on occasions, when reports are made direct to these public bodies, the institutional response is to "return" complainants to their communities, urging them to seek the help of "their" authorities (leader and Council) and to return to the public institution if they do not secure a resolution there.

Practices of this type legitimize the power and authority of internal decision-making instances over and above Departmental and national institutions, generating little confidence on the part of those who report acts of violence.

With regard to infrastructure, while institutions have the minimum material and human resources necessary, these are not sufficient to meet the needs and demands of the population. Gaps have been observed in financial and material resources and in numbers of trained staff.

Although coordinated work at the operational level (activities) can be seen, no evidence was found of programme level coordination (inter-institutional and intersectoral plans or programmes to comprehensively address violence and HIV).

The institutional response to HIV is, rather, piecemeal with little coordination. Because of this, actions lose impact since they tend to be isolated, piecemeal and not focused on common indicators or goals; no agreed strategies were identified. Although there are national policies, plans and programmes for violence and HIV, these are not put into operation at local or Departmental levels and action protocols are not adapted to the cultures of these populations, rather being general action guidelines for the entire population. Health informants acknowledge that they do not have an effective strategy to reach out to indigenous people who have been diagnosed with HIV; these people are often not linked to the health service and do not allow it to access them. The health service on its own does not have the resources to track such cases and on occasions contact with the patient is lost.

Regarding the type of actions undertaken by the various institutions, these are targeted at covering the population's basic needs, such as medical, legal, technical, psychosocial and, above all, educational services (more precisely, information-giving and awareness-raising) on different issues. No activities were identified whose goal was to address strategic needs, that is, having an impact on the power relations between the various groups, especially gender relations through actions to promote women's empowerment and promote new masculinities in males.

Most actions reported remained at the level of information, awareness-raising and education activities. These educational activities are also limited by the lack of indigenous volunteers and promoters to do this task in a way that is culturally adapted to each community and in its mother tongue. No evaluation was made of the degree of understanding of indigenous participants attending these activities.

The only training reported was vocational skills for women (baking, hairdressing, etc.) but these actions were not followed by subsequent monitoring or technical assistance, and no material or economic resources were made available for microenterprises to

be started. The result of this is that the training has no concrete result since the women lack the minimum resources needed to start their ventures.

No actions were described of a more structural type to try to modify the determinants that generate and maintain the inequalities that are ultimately reflected in acts of violence and cases of HIV infection. No action has been identified at institutional level to improve the conditions of poverty and exclusion especially of the indigenous communities settled in urban centres, those most exposed to marginalization, discrimination and institutional and structural violence.

In relation to evidence-based capacity of response, no evidence has been found of the use of information for decision-making or for planning or evaluation. All information is sent up to the central level and the Department has little control over its own strategic information.

In addition, there appears to be significant under-reporting especially of cases of violence in indigenous communities as these are referred in the first instance to internal authorities (leaders, councils and church pastors). Only cases that the above-mentioned cannot resolve or cases of extreme seriousness reach Departmental or national institutions where they can be recorded.

**Recommendations:** The barriers and difficulties found can be grouped into four main axes: i) Structural barriers (inadequate infrastructure, lack of material, financial and human resources); ii) programmatic (lack of coordination at policy, planning and programme levels); iii) operational (isolated, piecemeal actions and activities disconnected from broader, more comprehensive plans); and iv) monitoring and evaluation (little control over data generated at local level, preventing appropriate decision-making).

On the basis of these findings, the following lines of action have been outlined:

- Promote **volunteering** at every level and in every institution at Department level. The volunteer force is of vital importance for institutions to be able to reach communities. Institutions need to align themselves with populations rather than wait for populations to access them. It is suggested:
  - To review the situation of health promoters in the entire Department of Boquerón, especially of men and women traditional medical practitioners, and men and women spiritual leaders, the people the community turn to first in the event of illness.
  - Support the voluntary work of traditional midwives (empiric) and their training, to incorporate them into the health system with an intercultural approach.
  - Add value to the volunteer work of community leaders with training programmes and public recognition for those who are outstanding in their community service.
  - Expand the provision of services by volunteers beyond the health sector and involve them specifically in institutions addressing the issue of violence: police, prosecutor, courts, CODENI, municipalities and Departmental Government.
- Develop, validate, implement and evaluate local plans and programmes that respond using existing policies on violence and HIV. Plans and programmes must have indicators, agreed targets and differentiated strategies for each population. Each institution involved must act in its field of expertise in a joined up way with the other bodies involved.
- Involve indigenous communities and especially women and adolescents, as the segments of the population most vulnerable to violence and HIV, in the whole decision-making process, from planning,

through implementation to evaluation of the entire process.

- Create community participation opportunities, such as liaison committees where members of the communities represent their populations to institutional authorities. Participation should be expanded beyond the presence of leaders, since it needs to ensure the presence of the most vulnerable groups that have less representational capacity in community councils (particularly women and teenagers). These expanded participation mechanisms should be negotiated and agreed between the institutional authorities and the indigenous communities.

- Conduct advocacy to increase the budget for Departmental institutions. The minimum resources necessary have to be guaranteed for proper implementation of actions.

- The local health boards need to be strengthened and the participation of indigenous representatives on these boards promoted.

- At operational level, activities need to be broadened beyond awareness-raising or information-giving talks or skills training. Women and teenagers need empowerment processes for them to be able to generate actions aimed at changing the structures that maintain inequality. Information and awareness-raising alone on issues around violence and HIV will not necessarily generate changes to these structures.

- There is good practice in other settings that suggests that violence can be successfully combated through the economic empowerment of women. This study has described how economic violence operates in conjunction with other manifestations of violence. Many women have no choice but to return to their aggressors when they find themselves without the financial resources to maintain their families. It is important to develop institutional plans for the economic autonomy of indigenous women through vocational skills training, technical follow-up and access to microfinance to set up ventures that generate their own resources for the most vulnerable women.

- Take advantage of indigenous women's community vision and develop these productive projects collectively (community vegetable gardens, businesses where women work collectively, social cooperatives formed by women producers, etc.).

- With regard to monitoring and evaluation, promote the development of situation rooms in relation to violence and HIV, with inputs from different sources of information, to be used for the planning, implementation and evaluation of actions at the local level.

## 7.6 Research team

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