



**CENTRE** *for*  
**Aboriginal Health**  
**RESEARCH**

# **Best Practices in Intercultural Health**

**Executive Summary**

**Prepared for the Inter-American  
Development Bank and the Pan American  
Health Organization**

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# The Centre for Aboriginal Health Research (CAHR)

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# Introduction

The practice of integrating western and traditional medicines is fast becoming an accepted and ever more widely used approach in health care systems throughout the world. However, recent debates about the development of intercultural health approaches have raised significant concerns regarding regulation, efficacy, intellectual property rights, lack of cross-cultural research, access and affordability, and protection of sacred Indigenous plants and knowledge. Recognizing the global importance of this issue and the paucity of collaborative research on intercultural health, the Inter American Development Bank developed an international initiative on *Best Practices in Intercultural Health*.

Intercultural health in this study is understood essentially as practices in health and health care that bridge Indigenous Medicine and Western Medicine, where both are considered as complementary. The basic premises are that of mutual respect, equal recognition of knowledge, willingness to interact, and flexibility to change as a result of these interactions. Intercultural health takes place at different levels, including at the level of the family, practitioner, health centre, hospital, and health system. A “Best Practice” in health care needs to satisfy a series of criteria. It should: demonstrate a tangible and positive *impact* on the individuals and population served, be *sustainable*, be *responsive and relevant* to patient and community health needs and to cultural and environmental realities, be *client focused* including gender and social inclusion, *improve access, coordinate and integrate* services, be *efficient and flexible*, demonstrate *leadership*, be *innovative*, show potential for *replication*, *identify health and policy needs*, and have the *capacity for evaluation*.

The five case studies selected for this project were in the Latin American and Caribbean countries of Chile (Makewe Pelale Hospital & Boroa Health Centre, Temuco), Colombia (CRIC/AIC/IPS, Cauca), Ecuador (Jambi Huasi, Otavalo), Guatemala (Comadronas Association, Kaslen Foundation & Health Centre, Comalapa), and Suriname (Medical Mission & Amazon Conservation Team clinics, Kwamalasamutu & Pëlele Tëpu). The principle researchers were Drs. John O’Neil, Judith Bartlett, and Javier Mignone, from the Centre for Aboriginal Health Research in the Faculty of Medicine of the University of Manitoba. Local and national consultants in each of the countries provided invaluable assistance (see list of collaborators) during the course of the research, as did representatives from various indigenous organizations, communities, NGOs, local/state government bodies and international organizations.

## **The contents of the Report**

This Executive Summary provides a brief description of the data sources, findings, conclusions and recommendations of the study.

The full report provides a detailed description and analysis of the intercultural health models in the five study countries, with a primary focus on local Indigenous cultural traditions, medical practices, and how the emergent programs are impacting the health and social status of this population. The document begins with an Introduction and a Methods section, which is followed by a Summary of the case studies from each country (e.g. setting, health care system, and best practice model). The Findings of this study are organized according to the 15 key issues identified in the case study plan, designed in collaboration with the IDB. For logistical purposes, these framework issues have been broken down into four main headings, with three to five separate sections. Each case study is analyzed separately and the final sub-section provides a comparative synthesis. The report then presents the Conclusions and Recommendations, followed by several Appendices, including case study design, extensive detail on each case study (e.g. country level history and context; health service environment; epidemiological context; Indigenous history and cultural context; community/region description; and best practice case description), a review of recent literature on intercultural health, references, and document sources.

## **The data sources used for this report**

This study was informed by multiple data sources, namely the case studies of intercultural health models in each of the five countries and structured and semi-structured interviews, both of which were designed in collaboration with Indigenous leaders/local consultants and national consultants. Along with extensive literature reviews, detailed observational notes of fieldwork activities were made, numerous local documents were collected, and quantitative data was also gathered. The wide array of research participants, including Indigenous community members, government officials, western and traditional health care providers, and NGO staff, helped ensure an in-depth contextualization of the social, cultural, organizational, and political factors impacting the complex issue of intercultural health. A major limitation of the study however, was the absence of information systems in each country that would have permitted a more quantitative epidemiological assessment of health outcomes related to intercultural health practices. Not only is little data collected on indigenous health practices, but also state health information systems in most cases would not permit outcome analysis of western health care practices.

# Key Findings

## Cultural, Funding and Management Approaches to Intercultural Health Service Development

**Suriname-** The close collaboration of the Medical Mission (MM) with Amazon Conservation Team (ACT) in supporting the creation of traditional medicine clinics is evidence of a health system that has adapted to foster Indigenous practices. The traditional clinics have been developed in a manner to preserve locally defined traditional healing methods, thus ensuring continuance of the use of local plant and healer resources. The traditional clinics are funded through ACT, who receives most of its funding from private international donations and foundations.

**Guatemala-** In the Comalapa region both health care systems exist in parallel. Spirituality is the integrator of cultural and conceptual processes of Mayan concepts of health and illness and is a fundamental component in the way Mayan therapists are selected. However, there was little evidence that Mayan beliefs and practices were integrated into the formal primary health care system. State funding for health in Guatemala is in general very limited, and in the specific case of the *comadronas*, their clients pay them a relatively low sum out of pocket in cash or goods.

**Chile-** The restoration of the role of the *Machi* in Mapuche medicine within an intercultural health experience is linked to the recovery of Mapuche cultural identity. The Makewe hospital provides a full range of western health services and facilitates culturally appropriate services by having an intercultural health worker on staff, and ensuring that the hospital is managed by Mapuche. The government funds intercultural initiatives, and it contracts for provision of western health care services for the Makewe hospital.

**Ecuador-** The Jambi Huasi clinic in Otavalo promotes respect for Indigenous cosmovision and political commitment, and the principles of full participation of the Indigenous population. Its staffing also reflects an intercultural model, where western and traditional practitioners (physician and *Yachac*, western midwife and traditional midwife, etc.) have equal hierarchies and pay scales within the clinic. Jambi Huasi is funded through non-state means, currently operating on fee-for-service basis.

**Colombia-** The Asociación Indígena del Cauca (AIC) and the Instituto Prestadores de Servicios run by Indigenous organizations in Colombia support the integration of traditional healers and practices in the system and for other community initiatives. AIC manages the funding and contracts the health care delivery and preventive services, and the major funding comes through the government subsidized insurance plan. Intercultural health practices are funded from the marginal surpluses available from administrative fees.

## **Comparative Synthesis**

The notion of interculturality has different expressions across the case studies. Suriname is relatively clear-cut with two clinics, a western and a traditional, interacting in indigenous villages. The informal collaboration between these entities shows an approach that enhances the work of each and that has gained the support for this complementary approach from the Indigenous community. The experiences in Chile, Ecuador and Colombia are in essence western health care organizations offering intercultural health care services, although each one attempts it in somewhat different ways. The initiative in Guatemala attempts to articulate a western health care public institution with Indigenous organizations in the area of midwifery. The articulation does not appear to be successful yet.

The governance and management models of the five cases parallel the above. While the Suriname and Guatemala experiences have one entity in charge of the western medicine and another of traditional medicine, the other three initiatives have Indigenous entities managing both aspects. However, in all cases there are attempts at articulation of cultural approaches within the broader health system at all levels. Unfortunately it would appear that this goal is seldom realized and there is considerable evidence that racism is institutionalized in hospitals and other sectors of the health care system.

In terms of funding, the main funding for the traditional Indigenous medicine aspect of the initiatives mostly came from non-governmental donors, fee-for service, or surplus administrative funds re-allocated to this purpose. Rarely does government provide any direct funding for Indigenous health services. Given the limited and insecure basis for this funding, the Indigenous governance and management of the health delivery entities facilitated the integration of Indigenous health services into the health care system.

## **Perceptions of Opportunities and Benefits Provided by the Intercultural Health Initiatives**

**Suriname-** A strong relationship of trust has emerged between Amazon Conservation Team (ACT) and Medical Mission (MM) and between the organizations and the community. The Mission and ACT also have a memorandum of understanding assuring support for the Indigenous medicine program, and they were successful with a joint submission to the World Bank for additional funding to expand the program into Maroon villages. There was evidence that the Trio community has a stronger sense of cultural pride and a sense of ownership over the Indigenous component of the healthcare system.

**Guatemala-** In the Comalapa health centre, monthly meetings for *comadronas* and physicians provide an opportunity for these health care providers to learn about

each other's practice and values. The *comadronas* also play a key role in deliveries and primary obstetric care. The articulation of this Indigenous system with the western health care system facilitates the creation of appropriate and timely referrals when higher complexity medical care is required. Simultaneously it can help the public system to learn Mayan cultural norms and values and adjust its institutions to reduce cultural barriers.

**Chile-** Designing the Makewe intercultural health program required new discussions about the value of traditional medicine, the responsibility of community leaders in health, and the role of the state in intercultural health. Given the health ministry's limited budget, it is not clear how the currently funded Mapuche projects may be replicated on a broader scale. The Special Section on Indigenous Health in the Ministry is working on a program so that treasury will have direct budget lines to fund Indigenous traditional programs. The Makewe initiative also provides positive health management experience to Indigenous organizations.

**Ecuador-** The existence of Jambi Huasi was very valuable in terms of training western health care staff and facilitating communication and trust with Indigenous communities. The government's interest in ensuring cultural respect and access to care for Ecuador's Indigenous populations is evidenced in its program to increase cultural sensitivity of health care providers and to reach rural and remote communities. In Otavalo, Jambi Hausi appears to have enhanced Kichua cultural continuity and given communities an opportunity to have more pride in their own cultural health practices.

**Colombia-** The incorporation of western and traditional medicine in the health insurance scheme and health program delivery by Indigenous organizations, have increased access and improved quality of care. The case of the CRIC/AIC/IPS shows the powerful opportunities that are possible when Indigenous governance and management in health care and intercultural health is coupled with reliable funding. Another benefit is the increased respect given to the Indigenous management of health resources. This has had an indirect effect in enhancing Indigenous participation in municipal affairs.

### **Comparative Synthesis**

The case studies suggested a number of interesting opportunities provided by intercultural health initiatives. The opportunity of exchanging knowledge between both types of practitioners was particularly visible in Suriname and Ecuador, and to a somewhat lesser extent in Chile and Colombia. Despite efforts in Guatemala, the apparent lopsided arrangement, where the western practitioners "train" the *comadronas* instead of a two-way exchange, seemed to limit this possibility.

Another significant opportunity was an increase in trust among community members towards the health care system. Community trust of both the western and traditional clinics in Kwamalasamutu originated from a positive experience with each

clinic separately, but also seemed reinforced by the collaboration between the two. On the other hand, in the Guatemala experience, the lack of trust between the *comadronas* and the health centre has hindered progress in intercultural work.

In Chile, the political organization of Mapuche communities has strengthened their position and has enabled them to improve access to both western and traditional medicine. As well in Cauca, Colombia, CRIC, AIC and the Indigenous IPSs provide powerful opportunities for Indigenous governance and management of health care. In Otavalo, Ecuador, the Jambi Huasi experience has proved valuable in educating western health care staff to Indigenous health and facilitating communication and trust with Indigenous communities.

The benefits can be summarized as an apparent increase in cultural pride among the Indigenous communities. The situation in Guatemala is more ambivalent in this regard. Overall, the revaluing of traditional knowledge and practices and the increased sense of ownership and control appear to provide a wide range of potential benefits.

More specifically, the articulation of Indigenous and western systems facilitates more timely and appropriate referrals when higher complexity medical care is required. In Otavalo, the collaboration of the municipal government with Jambi Huasi and the midwives association has enhanced initiatives of maternal, child and adolescent health. In Cauca, the AIC experience has increased respect towards Indigenous governance and management of health systems. In Temuco, the Makewe initiative has created a new dialogue around the value and role of traditional medicine and the responsibility of indigenous leadership in health issues.

### **Perceptions of Constraints and Risks Associated with the Articulation of Indigenous and Western Health Systems**

**Suriname-** The Evangelical churches have negatively impacted traditional practices, especially ceremonial aspects related to healing. While the church has taken on some responsibility for the spiritual well-being of the community, mental health problems remain untreated. In terms of legislation, special provisions allow for health assistants to diagnose and treat patients, but none exist for traditional practitioners. However, ACT and the Medical Mission provide support to the traditional medicine clinic by providing training in basic hygiene and simple tests that can be assessed by medical clinic staff.

**Guatemala-** In Comalapa, *comadronas* face numerous impediments when trying to combine their services with the western health care system, including difficulty with the cultural content of training programs, stigmatization in mainstream hospitals, and little opportunity to interact with physicians or nurses. Other constraints include insufficient financial resources for the health system and the lack of coordination

between government and NGO staff in training and supporting *comadronas*. This marginalization engenders significant risk of suppressing the integrity of Mayan health care services.

**Chile-** Opposition from Evangelical churches to intercultural health programs, western bias in training at the Makewe hospital, and fears of College censure by physicians if they refer patients to Mapuche healers are among the problems experienced by traditional Mapuche practitioners. The legal system is also problematic because the Sanitary Code makes it illegal to practice medicine without a licence, and there is no provision to licence *Machis*. However, as healers are now publicly visible and their actions could be the target of police harassment, they are at risk if the government changes its policy.

**Ecuador-** In addition to system racism, intercultural health is constrained by inadequate financial support of the health care system, limited participation from Indigenous political bodies, and the lack of clear regulations for traditional medicine. However, efforts have been made to decrease malpractice through the development of appropriate training and oversight for the practice of traditional midwives. The Association of Midwives is also attempting to develop a council of wise women and men who can ensure that false practitioners are not doing traditional work.

**Colombia-** Numerous challenges face intercultural health initiatives, including political violence associated with guerrilla activity, culturally inappropriate state-run health regulations for traditional practitioners, and the competition that has emerged in the health insurance market. Despite laws that ensure Indigenous participation in the development of local health practices, few clear regulations have been developed or implemented in this regard and there is no evidence of a government legal framework for traditional practices.

### **Comparative Synthesis**

One set of constraints on intercultural health initiatives was related to the resistance from certain churches to traditional medicine or aspects of it. In Suriname, it was related to the sidelining of the ceremonial spiritual practices of Shamans, not the use of traditional medicines per se. In the other cases, the resistance by mostly Evangelical Christian churches was at times more overt. However, these constraints based on religious beliefs do not seem to have seriously limited any of the intercultural health initiatives studied.

Constraints related to health professionals differ across cases. The initiative in Suriname suggested a degree of openness by doctors and nursing staff to the opportunities offered by traditional medicine. The case of Guatemala reveals western health professionals with a position of acceptance, but a perspective that traditional practitioners should work as adjuncts to the western system. The Makewe and Boroa experiences in Chile appear to be impacting the medical profession in the sense that

more recent graduates appear drawn to practice in Indigenous settings precisely because of the interculturality. In Ecuador at the clinic level, integration between western and traditional practitioners seems to work well.

In all cases, it is in the relationship with personnel at the hospital level where serious resistance and racism exists, limiting the possibility of cultural appropriateness of services. The lack of clarity in relation to the legal framework for the practice of traditional medicine, and its interaction with western medicine, also creates many constraints. The situation in Chile is not currently of concern, but the ambiguous legal situation places the experiences at risk if the government's position changes. Even in Colombia, where important legislation provides reasonable legal backing to intercultural initiatives, the lack of proper regulations supporting an integrated system constrain further developments. Ecuador constitutionally protects traditional healers, but lacks clear regulations as to how the public health system can interact with them. In Guatemala, the legislative situation of *comadronas* is unclear, although the public health system seeks to both regulate them through a registration system and entice them to receive training. In Suriname, the lack of a regulatory framework does not seem to have put any constraints on the intercultural initiatives.

The lack of proper funding sources engenders many constraints across the five cases. This is particularly the case in Guatemala, where a very limited state health budget has prevented any broad articulation between the *comadronas* and the health system. The experience in Colombia suggests the relevance of Indigenous governance and management of health resources to enhance intercultural health. In Suriname without the central undertaking of a foreign NGO, the traditional clinics would not be operating. The Makewe hospital in Chile has achieved appropriate funding mechanisms and a small portion of these funds sustain the intercultural experience. Although Jambi Huasi is very efficient with its resources, these are quite limited and there are serious constraints in the development of broader intercultural health programs.

Finally, the lack of adequate data collection systems in all cases, Suriname being somewhat of an exception, seriously constrains these intercultural health initiatives in terms of planning, operations, evaluation and research.

### **Assessment of Impacts of Intercultural Health System Development**

**Suriname-** The involvement of community leadership and shamans in the development of the traditional medicine clinic created a type of service delivery that is in line with Trio cultural practices. This model has no direct cost to people, thus from a financial point of view there are no limitations to access. Although clinic attendance is not a direct measure of satisfaction, it provides evidence of regular use of both clinics, suggesting a relative degree of satisfaction. Another interesting indicator is that old and young, males and females, regularly attend both clinics.

**Guatemala-** The government accepts the practice of *comadronas* out of necessity, but only provides minimal support through provision of limited training opportunities and basic equipment. *Comadrona*'s fee per delivery is 100Q (US \$15), but they are usually paid between 20 and 30Q, versus 1500-4000Q for delivery by a private physician. Cultural barriers appear to play a profound role in deterring women from accessing the western health care system for prenatal, delivery and postnatal care, suggesting that the public sector needs to re-examine its practices to encourage and facilitate access.

**Chile-** Despite national health program goals to strengthen community, bilingual education, economic development, intercultural health, and improve accessibility, Mapuche leaders feel that they are unlikely to result in any sustainable improvement in intercultural health services. Yet, community leaders argue that they have seen a profound improvement in the health status of their people since the introduction of the intercultural program, due to the restoration of Mapuche cultural pride that *Machi* symbolizes, and improved access to primary health care services.

**Ecuador-** While intercultural health and traditional practices have a role in Ecuador, there is little evidence that the health system has made any effort to accommodate practice needs. Lack of external funding means that Jambi Huasi is not entirely sustainable in terms of administration and clinic infrastructure development. Jambi Huasi is an urban clinic and some rural Indigenous communities do not have the same access to traditional services as their urban counterparts. For some Indigenous leaders, this presents a real problem because traditional healing must be rooted in a traditional cultural context that is generally absent in the urban context.

**Colombia-** There is little evidence that the public health system supports traditional cultural practices. Health insurance coverage is a particularly contentious issue because the government cites census figures that coverage is 95%, whereas Indigenous organizations argue that it is at best 75% in some areas, much less in others. Access to intercultural health programs is also limited, in part to difficulty in delivering services to remote areas, and because many of these areas are no longer under government control.

### **Comparative Synthesis**

The most demonstrable impact in four of the five cases of the intercultural health initiatives was increased access to both traditional and western medicine. Guatemala was an exception because the intercultural model did not seem to be functioning properly. The evidence suggested that when Indigenous entities are involved in organizing health care there was a significant impact in reducing barriers to access and increasing user satisfaction.

The cost of traditional medicines and practitioners vis-à-vis western medicine is minor. What the case studies demonstrate is that the systems do not function in

opposition to each other. On the contrary, the real choice is about investing in inclusive intercultural health care models instead of systems based only on western health care.

A positive impact of most intercultural health initiatives was in relation to Indigenous community development, on revalorization of Indigenous knowledge, cultural continuity and pride as a people. These initiatives not only seemed to positively impact health care, but also the development of community participation and organization, which appeared to impact broader health determinants (such as nutrition, employment opportunities).

Since these initiatives are improving access, satisfaction, and treatment options in health care, as well as affecting health determinants, it can be expected that they are having a positive impact on health status. Nonetheless it is still necessary to incorporate data collection systems to be able to conduct effectiveness studies of both the systems and of particular practices. None of the health systems in the five countries has adequate data to assess the effectiveness of the western system, let alone the Indigenous traditional systems. The development of appropriate information systems would surely be of assistance to the intercultural health initiatives.

# Conclusions

## **Benefits and Impacts of Intercultural Health**

### ***Individual Health and Population Health***

The case study design and data limitation allowed us to only assess the plausibility of impact. Despite the anecdotal evidence at the individual level, there is no experimental evidence of efficacy, no quasi-experimental studies of effectiveness, and not even good baseline data. We can, nonetheless, extrapolate the possibility of impact due to evidence from other studies that suggest the relevance of social determinants of health, and of increased access and cultural appropriateness of delivery of care. As we will argue in the recommendations section, there is a serious need for proper information systems and proper effectiveness studies in all the cases reviewed. The irony is that the health systems under Indigenous control appear to have more interest and possibility, with proper technical and resource support, to develop proper information systems than those under state administration.

It is very difficult to assess the impact of Indigenous medicine on individual health status. However, in all of the cases we heard testimonials indicating that the treatment received from Indigenous healers resolved a variety of illnesses. Indigenous medicine plays a particularly important role in resolving the spiritual, psychological and physical consequences of historical trauma. Indigenous people globally have had similar experiences as victims of colonization, oppression and genocide, and their approaches to healing the whole person are recognized globally as important healing strategies.

### ***Access to PHC Health Services***

Intercultural health care models provide important opportunities for extending coverage of primary health care in the case studies examined. In particular, Indigenous midwives are responsible for between 50 and 90 % of births across the countries. Indigenous midwives not only provide technical assistance and family assistance to birthing mothers, but with appropriate support and training from the western health care system, they also help facilitate appropriate referral of women with high-risk of pregnancy related complications to western health care facilities. Although there is not extensive integration of Indigenous and western health services, we did find evidence that programs by Indigenous organizations increase confidence in the Indigenous community that their values and beliefs will be respected when they access western health services.

## **Cultural Safety in Western Health Service Environments**

All case studies (except Suriname) provided evidence that Indigenous people experience considerable racism and discrimination in the context of western health services. This was particularly true for pregnant women who routinely refuse to access hospital services even under the direst circumstances. Negative consequences are often erroneously attributed to the traditional midwife. In all of the studies, we found that the introduction of intercultural health services has impacted positively on the emergence of cultural safety as an important concept in the provision of health services to Indigenous people.

### ***Economic Benefits and Impacts***

For the most part, intercultural health initiatives are inexpensive to the State because Indigenous communities prefer to maintain reciprocity and community support as the economic basis for healing. Organizational development of intercultural programs has been financed primarily by international NGO's. However, traditional services are often used as a first line of therapy for childbirth, mild to moderate illnesses and psychological distress, at a substantial cost savings to the formal health system.

### ***Community Development and Self-Government***

In 'developed' countries there has been a move toward "integration" of Indigenous programming into mainstream departments. 'Mainstreaming' attempted to decrease Indigenous "claims to legal entitlement and differential treatment" yet has paradoxically resulted in increased autonomy through the capacity development resulting from assumption of program management roles (Papillon & Cosentino, 2004). A key finding from this investigation is that intercultural health programs play very significant roles in providing a 'space' within which to create the capacity of Indigenous communities to develop autonomous self-governing organizations and communities. These programs help to re-affirm the central importance of Indigenous spiritual and social values in communities, which in turn provides the confidence required to assert autonomy and independence in relations with the wider society and the State.

## **Challenges and Constraints in Intercultural Health**

### ***Discrimination from Western Health System***

Despite State initiated constitutional change and attempts to provide cultural sensitivity training within the health system, there is little evidence of progress toward

acceptance of traditional medicine practices within the established health system. An especially serious problem is the fact that medicine and other health professions do not receive appropriate initial or ongoing training in cultural sensitivity and lack understanding that Indigenous populations have radically different ideologies and practices from the western world.

### ***Indigenous Community Factors***

There is a tension between groups regarding the environment in which traditional medicine should be practiced. There were also differing opinions about the commercial marketing of traditional medicines. Some feel the separation of the traditional medicines and the healers from the community environment is not appropriate and indeed reduces the efficacy of healing. Some felt it was appropriate to capitalize on marketing traditional medicines for the purpose of community development and self-governance/self-reliance. Thus it is important for Indigenous populations in each country to undertake or expand on processes to advance the issue of how to evolve access to traditional systems in contemporary society without loss of cultural integrity.

### ***State Policy***

In each of these countries, two systems of health services exist; the unrecognized unregulated *Indigenous Traditional Health System* and the formally recognized regulated *Allopathic Health System*. Allopathic medicine has gone through reform during the last decade, most often moving toward decentralization and increasing privatization. Although all have attempted to maintain a core of first level services through insurance schemes or contract-based health centers, there has been substantial destabilization of the social safety network. In some countries a high proportion of the poor, including Indigenous populations, are without adequate access to allopathic health care services. The fact that Indigenous populations, particularly in rural areas, rely on traditional practitioners as their first choice of therapy has mitigated significant consequences from decreased access to allopathic medicine.

There are also advocates attempting to retain Indigenous traditional practices as more culturally congruent for significant proportions of the populations. In all countries, health ministry support for intercultural health and traditional medicine practices exist, but there is also an attitude that the care provided by traditional providers is often perceived only as a temporary extension of the conventional health system. One of the complicating factors in the policy environment is the gap in communication between government and Indigenous communities. Due to the institutional policy development process, ministry personnel are unable to comment on what/why/whether certain actions are or are not being taken, and what is in the planning stage for further development.

## ***Regulatory Environment***

Constitutional change in some countries (as early as 1988) has resulted in minimal or no development in terms of enabling legislation and clear regulations relative to how the existing health system might best interact with traditional Indigenous practitioners. Such a situation leaves both Traditional healers and Western physicians without guidance and at risk for litigation from articulating intercultural health practices. Those western trained physicians who do participate in practices with cross referrals to Indigenous practitioners are at risk of losing their medical licence. At the same time, Traditional practitioners can be accused of practicing without a licence and/or contravening health regulations. Although health ministry officials in some countries stated that health regulations either do not apply legally, or are not applied to Indigenous healers, there is not real protection for healers should government and political orientation change. Given the variety of traditional practitioners in each country, the development of regulations guiding such practice, in consultation with Indigenous populations, is an important avenue to explore.

## ***Economic Sustainability***

Traditional health systems have had a sustainable existence for thousands of years. Potential traditional practitioners respond to a 'call to service' from the spiritual dimension and therefore are not motivated by financial gain. The role of healer is a 'calling' rather than a profession or job may be a factor in the sustainability of traditional practices, which makes them continue to be a viable and inexpensive source of healing services. The issue of economic sustainability of intercultural health experiences is a complex question that needs to be examined from the perspective of the Indigenous communities as well as government. Intercultural health experiences become an intersect between traditional and allopathic medicines, a site for access and of coordination between the two medicines.

## **Risks and Limitations of Intercultural Health**

### ***Commercialization***

Two distinct aspects are related to the risk of commercialization. One is what has been identified as "biopiracy" where scientists and corporations use the traditional Indigenous knowledge to identify medicinal plants. Aside from other considerations, a serious problem is that those with the traditional knowledge receive no compensation or profit sharing for their intellectual property. Furthermore, medical drugs produced by these companies are then sold at prices that are inaccessible to Indigenous communities. The second aspect is related to the commercialization of natural drugs and traditional practices by Indigenous communities and organizations.

### ***Inequities in extension of Primary Health Care***

The study observed the central role of strong Indigenous organizations in extending western health care coverage. Stronger communities are better able to lobby for resources to build or better equip local health centres. The success of these communities simultaneously suggests that the state, regional Indigenous organizations and NGOs should monitor these developments since inequities in health care could emerge. The stronger and more experienced communities will be more successful at generating resources, but the less organized and experienced communities may be left out of these developments. One way to avert this risk is to work with the weaker communities to ensure they have access to health care resources on par with other communities. A second issue that emerged in some of the case studies is the accessibility of the poor non-Indigenous population to health care.

### ***Institutionalization and loss of autonomy***

The tension between Indigenous and state control of health care is real and needs to be acknowledged. There are two main risks. First is the institutionalization of traditional health, where traditional practices become defined and structured, and ultimately subsumed under western paradigms. The second risk relates to the loss of autonomy of Indigenous communities and organizations in terms of how they structure, organize and run health care systems that incorporate both medicines. The value of community control is lost to the logic of state control.

### ***Popularization***

The risk is that these practices may be conducted outside of a cultural and community context that properly validates the healers and their practices. This has led to unqualified practitioners offering a variety of alternative health services that may include modified aspects of Indigenous medicine. These “illegitimate” practices are sometimes confused with Indigenous medicine by the larger society and negative perceptions may emerge.

# Recommendations

## **1) Provide Support to Intercultural Health Policy at State Level**

### **1.1. Development of culturally appropriate regulatory environment**

A constitutional basis for the traditional health system and the utilization of traditional practitioners is in place in some countries (Chile, Ecuador) although none has moved very far toward developing regulations under existing Indigenous Law or amending the State health regulations to accommodate such constitutional changes. One country (Ecuador) has made special provisions to State health regulations to ensure that traditional practitioners will not be arrested for practicing traditional medicine. Others simply do not apply the health regulations to Indigenous healers, while others (Suriname) take the position that traditional and alternative health service utilization is a personal issue.

Efforts are also being made to provide cultural sensitivity training to allopathic health personnel and government departments, but evidence of positive results is sketchy. Indigenous populations still appear to avoid utilizing allopathic health services due to the experience of poor treatment and racism. The gap in regulations results in significant confusion on the part of allopathic health professionals who believe that, by law, they cannot interact with traditional health practitioners. Those who choose to interact with traditional practitioners are at risk for professional censure.

There is an urgent need for a *regulatory framework*, which should include the areas of: Indigenous representation in national health strategies dialogues; equity for Indigenous populations relative to public health expenditures; access to culturally based holistic health approaches; Indigenous management of health services financing including traditional health services; Indigenous and allopathic dialogue and mutual capacity building; allopathic institutional cultural competency; data instrument development and implementation for monitoring of intercultural, allopathic (particularly for Indigenous populations) and traditional services, including for rural Indigenous populations; and medicinal plant production / processing and intellectual property rights.

### **1.2 Development of contractual models for promoting Indigenous autonomy in health system development**

Contractual models in Indigenous health governance have been demonstrated internationally as important policy developments for promoting independence and autonomy (Lavoie 2004). Our investigation indicates that the Colombian approach to contracting with Indigenous organizations to provide health insurance and western

health services has resulted in strengthening Indigenous organizations and in an accessible and culturally appropriate health care system for Indigenous communities. Despite limitations, the Colombian model best approached the standards of best practice in intercultural health in this aspect.

A contractual approach was also observed in Chile to a somewhat lesser extent than in Colombia. Here, Indigenous communities were able to contract with the State to provide primarily western health services in several regional and community clinics. However, this model tends to reward communities with stronger and more outspoken leadership and has the potential to create significant inequities in the provision of health services to Indigenous communities on a regional basis.

In both Colombia and Chile, Indigenous organizations have managed to support traditional medicinal practices through surplus funding resulting from efficient management of their western health service contracts with the State. However, State policy reform is needed in both cases to enable indigenous health service providers to include intercultural health programs within their contractual agreements. These contractual agreements tended to facilitate a more integrated, widely accessible, and sustainable approach to intercultural health programming. We recommend that State policy seek to strengthen the independent and autonomous development of Indigenous intercultural health systems that are available on a regional basis to communities.

## **2) Provide Support to the Orientation of the Western Health System towards Intercultural Health Programs and Practices**

In every case study except Suriname, discrimination among western health care practitioners and administrators against Indigenous healers and practices was a major constraint on the successful implementation of these programs. Even in situations where western health care providers professed support for intercultural programs, they were quick to blame Indigenous health care practitioners for morbidity and mortality due to problems that emerged from poor referral practices. While negative outcomes were referred to as “healer’s iatrogenic problems”, we found that when referral problems occurred, they were more likely the result of refusal by Indigenous clients to access western services out of fear they would be poorly treated and disrespected.

In several case studies there are State initiated efforts to provide cultural orientation to health service providers directly involved in providing services to Indigenous peoples. These efforts would be significantly strengthened if Indigenous organizations had a greater role to play in the design and implementation of cultural orientation programs. It was also evident that most of this cultural orientation effort is focused on western health care practitioners already in practice. There appears to be relatively little attention to this issue at the training level, with some notable exceptions (Chile). Universities and other training institutions need to be supported with technical advice and resources to include more cultural orientation programming in their curricula.

### **3) Support Indigenous Organizations and Communities in the Development of Health Programs**

Past and continuing experience with lack of respect for Indigenous cosmology(s) and traditional practices has resulted in minimal trust of government by Indigenous communities. States tend to view traditional practices as entities to be seconded for the purpose of extending the reach of allopathic medicine. Government also tends to consider its 'mobilization' of Indigenous communities as 'successful' in providing services to underserved communities. Indigenous leadership on the other hand do not consider that success can result from programs that lack self-governance. As well, when Indigenous communities 'self-mobilize' and demand access to culturally appropriate health services and health promotion, authorities often see this as 'agitation' and even 'aggression' that must be suppressed.

Given the discussion on cultural continuity as a determinant of health, and the locus of control relationship with morbidity and mortality, the need for Indigenous control over health services is critical. One problem is the tendency for governments to bypass the Indigenous political bodies in favour of developing ministerial appointed advisory committees, which operate at a level of collaboration in program development rather than empowerment at a governance level. At the same time, Indigenous governed technical health organizations are often called upon to play roles that are more appropriate to Indigenous political bodies. This leaves Indigenous health services and political bodies at risk for both inter-group tension and disruption, or even potential failure. When a health service is playing a role that is more appropriate to a political voice, its time is being taken away from its primary purpose, which is service provision. When government is not providing access to resources for active participation of Indigenous peoples through their chosen political bodies, these bodies are not positioned to carry the role of advising Indigenous health services on key policy questions, including those that go beyond but affect the health sector. This creates instability in the health service environment.

### **4) Provide Technical and Financial Support to Develop Information Systems for Monitoring, Evaluation and Research Purposes**

A common situation encountered both at the state level and at the level of health care settings across the five case studies was the lack of good and comprehensive data on the health status of Indigenous people and of delivery of health services. At the state level censuses need to be designed to gather information that captures valid socio-demographic and economic data on Indigenous people. Public health surveillance information is also limited, thus technical and financial support to government and Indigenous organizations would assist in achieving a proper surveillance system. Health surveys are also needed to gather data on the social determinants of health of Indigenous people, on their utilization of western and traditional health systems, on possible barriers to access, outcomes. The health care delivery organizations themselves need both technical and targeted financial resources to develop information systems for planning, monitoring, evaluation, and research purposes. As well,

experimental and quasi-experimental studies on efficacy, effectiveness, and efficiency should also be pursued in specific cases, within a context of mutual respect between the different paradigms of knowledge.

#### **5) Support the Exchange of Ideas and Models Across Countries within Latin America and Between North and South America**

Evidence from the case studies showed the importance of the dissemination and exchange of ideas and models. Many of the best practices examined had been positively influenced by other experiences within the same country and/or from other countries. Nonetheless, more exchanges are required to expand, improve and strengthen intercultural health models. These exchanges should cover technical, cultural, and political dimensions. In particular, we recommend the exchange of intercultural health experiences among Indigenous organizations and communities, and among municipalities and regions, within and across Latin American, North American and Caribbean countries. As well, investment in educational exchanges particularly (although not exclusively) of health professionals, of traditional healers, of medical, nursing and other health care students, of health administrators and researchers, and of indigenous leadership responsible for health, could be of significant benefit.

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