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Harmonization of Indigenous and Conventional Health System in the Americas

Strategies for Incorporating Indigenous Perspectives, Medicines, and Therapies into Primary Health Care

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Contents

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1. Executive Summary

This document is based on the experiences of a specific population, the indigenous population, whose needs have been an ongoing concern of the Pan American Health Organization (PAHO) throughout the processes of promoting equity in the Region of the Americas. The following document is part of the activities connected with the implementation of the Health of the Indigenous Peoples Initiative and provides continuity for the activities contained in the second line of action of the "*Strategic Framework and Action Plan 1999-2002 of the Health of the Indigenous Peoples Initiative,*" known as *Intercultural Frameworks and Models of Care.*

Over the centuries, indigenous peoples have searched for ways of maintaining and restoring their health. This document attempts to aid this search by addressing the issue of incorporating indigenous perspectives, medicines, and therapies into primary health care as one of the strategies for harmonizing indigenous health systems with the conventional health system. Although in practice there are links between the different health strategies and resources of both systems, in the majority of cases, relations between the indigenous and conventional health systems have not been harmonious.

In recent years, concern has been growing in the world about the inequities among excluded sectors of the population, among them indigenous peoples, and the shortcomings of the health care strategies currently in place. The precarious health and living conditions of these population groups exacerbated by an epidemiological profile marked by deficiency diseases, chronic degenerative diseases, and health problems linked with urbanization, violence, alcoholism, and drug abuse have confirmed the limitations of the conventional and indigenous health systems. These shortcomings justify the urgent need to rethink legal, conceptual, methodological, and operational aspects to afford people equitable access to healthy environments and quality care.

Furthermore, the current interest in so-called traditional, complementary, and alternative medicine is evident. Incorporating indigenous perspectives, medicines, and therapies into primary health care is part of this interest, conceived as one of the strategies for harmonizing indigenous health systems with the conventional health system in an effort to improve health care for the population, particularly the more than 43 million indigenous people living in the Americas. The term *incorporation* may be used as a synonym for association, inclusion, or access, and the term *harmonization*, as a synonym for conciliation, interrelation, consensus-building, or mediation.

From the indigenous perspective, the world is viewed as an integrated whole; therefore, indigenous health systems cover aspects that go beyond the conventional reductionist paradigms. The various dimensions associated with this holistic view are explained through the conceptual framework that is termed *sociocultural analysis.* This type of analysis considers the cumulative effects of exclusion, the population's heterogeneity, health care heterogeneity, health resource heterogeneity, and the actual perspectives of indigenous peoples and their environments as intersecting axes in the different categories of conventional analysis.

In the area of health systems and services, *sociocultural analysis* promotes an *intercultural approach to health* in the strategies of treatment, rehabilitation, disease prevention and health promotion. This approach seeks to encourage recognition, respect, and an understanding of the social and cultural differences between peoples, their knowledge, and their resources to improve health strategies by incorporating their perspectives, medicines, and therapies into the national health systems. This process

requires the application of a legal framework that facilitates social participation, indigenous practices, and the protection and conservation of indigenous knowledge and resources. It similarly requires the generation of knowledge and paradigms that expand conceptual frameworks and facilitate an understanding of indigenous knowledge and its incorporation into the training and development of human resources. For the practical application of the intercultural approach to health, various strategies have been identified. These have been grouped into three areas of action: 1) harmonization of laws; 2) harmonization of concepts; and 3) harmonization of practice. Each of these areas of action is described below.

Harmonization of laws is a process in which legal frameworks–policies, laws, regulations, and standards—are adapted to the social and cultural characteristics of indigenous peoples. It is a process aimed at establishing an equitable relationship between indigenous peoples and the society of the nation state. In the specific area of health systems and services, the harmonization of laws requires the creation of legal frameworks that facilitate access by the indigenous population to quality health care while officially recognizing the contributions of indigenous health systems to the maintenance and restoration of the population's health.

Harmonization of concepts is a process geared to recognizing indigenous knowledge, practices, and health resources as health systems. This process seeks the generation of new and alternative paradigms that make it possible to understand the **complexity** of the material and symbolic wealth of the theories and practices that indigenous health systems utilize for maintaining and restoring health. It is the generation of conceptual frameworks, instruments, and methodologies that will contribute to an analysis by contrasting the general theory and perspectives on health with the particular situation of indigenous peoples and, more particularly, with a specific community or group of communities.

Harmonization of practice is a process that promotes the formulation and implementation of models of care that make it a priority to take into account the social and cultural characteristics of the beneficiary population, their community resources, and their specific epidemiological profiles. This requires the training and development of human resources—indigenous and non indigenous—capable of respecting, understanding, and responding to the different social and cultural contexts of the beneficiary population to deliver comprehensive health services to individuals and the community alike.

In addition to the respective strategies in each of these **three** areas, indicators that orient their operationalization have been identified and will be presented later in this paper.

As an invitation to delve further into these ideas, this paper contains examples of experiences and processes under way to benefit the health **of** the indigenous peoples of the Americas.

2. Introduction

Few societies today are limited to single mechanisms for procuring and maintaining their health. In a given geographical area it is possible for health systems based on biomedical principles to exist side-by-side with others grounded in the cosmic vision and traditional wisdom of the population. These systems offer a wide range of therapeutic and human resources for individual and collective health. In practice, the demand for and utilization of these resources has determined the multifaceted nature of health care.

Indigenous peoples have incorporated approaches from other health systems into their knowledge and practices. At the same time, the conventional health system has benefited from indigenous knowledge[1]. The indigenous peoples knew the "miraculous" properties of curare, quinine, sarsaparilla, guaiacum, coca, among other substances and medicinal plants that are used in conventional medicine.

In the past two decades, the so-called developing countries and developed countries have generated an interest in emphasizing quality of life, healthy environments, healthy lifestyles, and the advantages of natural and traditional resources and applying them to health care strategies. Traditional, complementary, and alternative medicines have gained ground in national health programs, supported in a number of cases by the necessary legislation.

However, the trends in demand are different. While the trend toward the use of alternative therapies in developed countries is due to the search for better health care, in the developing countries this demand is related to economics and access. In the case of indigenous medicine, it is the only available source of health care (OPS, 1998a). Of the 100 million people lacking regular access to health care, 40% are indigenous (Pan American Health Organization, 1998a).

The Americas in general has witnessed significant progress in several aspects of health, such as the sharp decline in mortality and morbidity of a number of diseases. However, the improvements in the health status of the population differ among the countries and among different population groups within the countries. The gap between socially marginalized groups, among them the majority of indigenous peoples, and the groups with the greatest access to goods and services is growing wider.

Illiteracy, unemployment, lack of access to land, high rates of morbidity and mortality from avoidable causes, and serious limitations in access to and utilization of services owing to geographical, economic, and cultural barriers are problems affecting the majority of indigenous communities. In light of this reality, in 1992 the PAHO Subcommittee on Planning and Programming proposed that the health and well-being of the indigenous peoples of the Americas be examined more thoroughly.

The desire of the Member States of PAHO to address the health needs of the indigenous population has been expressed in agreements, declarations, laws, plans, and directives that favor the development of indigenous peoples. This has led to the implementation of health strategies that focus on indigenous communities. However, the presence of structural factors such as poverty, illiteracy,

[1] In 1979, it was calculated that the Southern hemisphere exported to the Northern Hemisphere an average of 70 million dollars per year in medicinal plants, this trade amounted to more than 5,000 million dollars in 1993 (Universidad Andina, Subsede Quito, 1994).

unemployment, lack of land and territory that affects the majority of indigenous peoples, added to the existing health services structure, has not permitted adaptation of the strategies to the particular characteristics of the various indigenous peoples of the Region. Where physical access is not an issue, there are often financial, geographical, or cultural barriers to the use of health services. Indigenous communities depend on traditional healers and spiritual leaders to promote health and to prevent and treat common illnesses; these resources often tend to be the only permanent resources available to them (OPS, 1998a). WHO estimates that traditional midwives attend up to 95% of all rural births and 70% of urban births in developing countries (World Health Organization, 1996).

The indigenous peoples' disease profile demands a deeper look at basic needs and services. Suffering from communicable and deficiency diseases has been accompanied by a progressive rise in morbidity and mortality from chronic degenerative diseases, especially cardiovascular disease and cancer. In addition, there exist public health problems associated with urbanization, industrialization, acculturation, and the growing impact on society of consumerism, violence (suicides, homicides, and accidents), alcoholism, drug abuse, contamination, degradation, and destruction of the environment in addition to the exposure to toxic wastes in the workplace and general environment. The complexity of this epidemiological profile has made clear the limitations of and challenges for both the conventional and indigenous health systems as well as the need to harmonize the resources of these systems in order to address the health problems of the indigenous population.

The document responds to the "*Strategic Framework and Action Plan 1999-2002 of the Health of the Indigenous Peoples Initiative*" and constitutes one of the strategies for operationalizing the second line of action of the Plan: *Intercultural Frameworks and Models of Care.* This document also notes the processes under way in the countries to improve health care for indigenous peoples and acknowledges the need to incorporate indigenous perspectives, medicines, and therapies into primary health care as one of the mechanisms for guaranteeing equitable access to quality care and the utilization of existing resources. It supports the creation of models that maintain technical excellence while promoting an understanding of the social and cultural variables that impede the populations' access to health care and, therefore, determine the health and living conditions of peoples.

As a frame of reference, the first part of the document summarizes the trajectory of PAHO's Health of the Indigenous Peoples Initiative, particularly with regard to including indigenous perspectives, medicines, and therapies within the activities connected with the implementation of the second line of action of the "*Strategic Framework and Action Plan 1999-2002 of the Health of the Indigenous Peoples Initiative,*" known as *Intercultural Frameworks and Models of Care.*

This is followed by a conceptual approach that attempts to define some terms, refine certain concepts, and understand the dimensions linked with a holistic view of health. This conceptual approach is called *Sociocultural Analysis*, whose practical application to health systems and services is to create and put into operation an intercultural approach to health, resulting in the harmonization of the indigenous and conventional health systems.

Finally, this document identifies strategies and indicators to guide the incorporation of indigenous perspectives, therapies, and medicines into primary health care. These strategies have been grouped into three areas of action: 1) harmonization of laws; 2) harmonization of concepts; and 3) harmonization of practices.

To effectively put these guidelines into effect, indigenous and non-indigenous peoples and different entities involved in health, from health professionals to policymakers and intellectuals, should revalorize the indigenous knowledge within a context of recognition and respect for indigenous cultures.

This document is not confined to the experiences presented. It is a work in progress that seeks input from readers and the processes under way in each country that contribute to the well-being of the indigenous peoples of the Americas.

3. Approach to Indigenous Perspectives, Medicines, and Therapies in PAHO

3.1 The Health of the Indigenous Peoples Initiative

This document's framework is based on the mandates found in Resolutions CD37.R5 and CD40.R6 of PAHO and the Health of the Indigenous Peoples Initiative. The process involved in implementing the Initiative in the Region of the Americas is summarized below.[2]

The Health of the Indigenous Peoples Initiative arose in PAHO in 1992 during the commemoration of the 500th anniversary of the arrival of Europeans in the Americas. It was developed as a strategy to systematically address the health problems of indigenous peoples with the cooperation of the indigenous people themselves.

In 1993, after a consultative meeting held in Winnipeg, Canada, with the participation of representatives of indigenous peoples, governments, academia, and nongovernmental organizations from 18 countries, PAHO and its Member States made a commitment to work with indigenous populations to improve their health and well-being, taking into consideration the indigenous groups' particular ancestral knowledge. This commitment was explicitly outlined in Resolutions CD37.R5 (1993) and CD40.R6 (1997) and in the principles (Table 1) and directives of the Health of the Indigenous Peoples Initiative.

Table 1. Principles

- Holistic approach to health
- Right to self-determination
- Respect and revitalization of indigenous cultures
- Reciprocity in relations
- Right of indigenous peoples to systematic participation.

The Member States of PAHO ratified the principles of the Health of the Indigenous Peoples Initiative and signed Resolution CD37.R5 in 1993, demonstrating their political commitment to giving priority to actions that contribute to the well-being of the indigenous peoples and their respective countries. In 1997, Resolution CD37.R5 was ratified through Resolution CD40.R6.

In order to implement these resolutions in the present quadrennial, the "*Strategic Framework and Action Plan 1999-2002 of the Health of the Indigenous Peoples Initiative*" has identified three interrelated lines of action:

[2] Details of the trajectory of the Health of the Indigenous Peoples Initiative in the Americas are found in document No. 8 of the Series "Health of the Indigenous Peoples: Health of the Indigenous Peoples Initiative. Progress Report."

1. *Strategic planning and alliances:* In this line of action, the activities are geared towards supporting the countries to formulate and implement public policies and integrated strategies for health systems development that are designed to achieve equitable access for indigenous peoples, all within the context of sectoral reform.

2. *Intercultural frameworks and models of care:* In this line of action, the activities support the countries in designing and executing frameworks and models of care that help lower the barriers faced by indigenous peoples in achieving health equity as well as access to health services. This line of action also includes the development of methodologies and tools that facilitate the incorporation of indigenous perspectives, medicines, and therapies into the national health systems, particularly in primary health care.[3]

3. *Information to detect and monitor inequalities:* In this line of action, the activities promote improved collection, production, and dissemination of information on the health and living conditions of indigenous peoples.

The resulting benefits of these activities will improve the health situation of indigenous peoples, providing them with equitable access to quality health services that are both culturally appropriate and sustainable.

This document constitutes one of the strategies designed to lend continuity to the implementation of the second line of action: *Intercultural Frameworks and Models of Care.*

3.1.1 Intercultural Frameworks and Models of Care.

Consistent with the demands of indigenous peoples, one of the key principles of the Initiative is the importance of respecting and revitalizing indigenous cultures. The health efforts of the Organization and Member States of PAHO, as such, must be used to address the inequity that negatively impedes the development of indigenous peoples. Tables 2 and 3 list Resolution CD37.R5 and Resolution CD40.R6's articles, which contain the following specific mandates:

[3] Primary health care is essential health care, based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation, at a cost that the community and country can afford to maintain at every stage of development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community (Declaration of Alma-Ata. Article VI. Kazakhstan, Former USSR, 1978).

Table 2. Resolution CD37.R5–Article 2, Section b

To urge the Member States to:

b) Strengthen the technical, administrative, and managerial capacity of national and local institutions that are responsible for the health of indigenous populations with a view to progressively overcome the lack of information in this area and ensure greater access to health services and quality care, thus contributing to a higher degree of equity;

d) Promote the transformation of health systems and support the development of alternative models of care, including traditional medicine and research into quality and safety, for indigenous populations within the local health system strategy;

In 1997, recognizing the growing evidence of inequities in health status and access to basic health services that affect approximately 43 million indigenous people in the Americas, the 40th Directing Council urged the governments to intensify their efforts to provide health care for indigenous populations by ratifying Resolution CD37.R5 through Resolution CD.40.R6. Resolution CD.40.R6 contains the specific mandates with regard to health care for indigenous peoples within the framework of sectoral reform (Table 3).

Table 3. Resolution CD40.R6

It urges Member States in the process of implementing health sector reform to be persistent in their efforts to detect, monitor, and eliminate inequities in the health status and access to basic health services of vulnerable groups, especially indigenous peoples.

It calls to the attention of Member States the fact that renewing the goal of health for all requires that sustainable solutions be found to address the economic, geographic, and cultural barriers to adequate care for vulnerable groups.

Since 1993, several activities have been carried out to implement these mandates.[4] During the first years of the Initiative, the work at Headquarters and the PAHO/WHO Representative Offices contributed to the identification of strategies, work areas, and clear goals for the *PAHO/WHO Plan of Action for Promoting the Initiative in the Region of the Americas 1995-1998*. The third component of the Plan, *Strengthening and Development of Traditional Health Systems,* was devoted to understanding indigenous health systems. The emphasis in this stage was on legislative development and research.[5]

[4] The list of publications issued by the Health of the Indigenous Peoples Initiative contains several documents that systematize the experience of PAHO in incorporating indigenous perspectives, medicines, and therapies in the Region of the Americas.

[5] Details of these activities are found in: *Strengthening and Development of Traditional Health Systems: Organization and Delivery of Health Services in Multicultural Populations. Health of the Indigenous Peoples Series. No. 6, in the Progress Report of the Health of the Indigenous Peoples Initiative. Health of the Indigenous Peoples Series, No. 8* and in *Strategic Framework and Action Plan* 1999-2002 of the Health of the Indigenous Peoples Initiative.

After the 1997 evaluation of the 1995-1998 Plan, the *Strategic Framework and Action Plan 1999-2002 of the Health of the Indigenous Peoples Initiative* was formulated. The Plan's second line of action, *Intercultural Frameworks and Models of Care,* includes actions that lend continuity to the work done since 1993--actions that contribute to the harmonization of indigenous health systems with their many health providers and practices, and the conventional health system.

At this stage, the activities expand the conceptual frameworks that support training for health workers so that they provide culturally appropriate care to multicultural communities, in addition to preparing and field-testing educational guidelines and instructional materials to ensure that the indigenous perspective, medicines, and therapies are incorporated into the existing models of care. Moreover, the Plan's second line of action prioritizes the formulation and dissemination of norms for the regulation, legitimization, and legal recognition of traditional healers. In addition, the plan discusses such aspects as intellectual property and the preservation of biodiversity, in collaboration with national and international legislative bodies. Since many indigenous peoples live in sparsely populated areas, the activities in this line of action stress the identification, systematization, documentation, and dissemination of innovative strategies to provide access to basic public health and clinical services through Technical Cooperation between Countries (TCC) projects.

Among the more recent activities that specifically address the matter of indigenous health systems, there are:

- The project "*Traditional Health Systems in Latin America and the Caribbean: Baseline Information"*[6] This project was carried out in 1997 in collaboration with the Office of Alternative Medicine of the U.S. National Institutes of Health and the National Institute of Health Public of Cuernavaca, Mexico.

- The *Working Group on Human Resources and Cultural Diversity,* held on September 9th–11th, 1998 in Managua, Nicaragua[7] with the participation of representatives of indigenous peoples, institutions that train human resources, ministries of health, PAHO, and nongovernmental organizations from Bolivia, Ecuador, Guatemala, Honduras, Mexico, Nicaragua, and Peru.

- The *PAHO-WHO Working Group on Traditional, Complementary, and Alternative Medicines and Therapies,* held in Washington, D.C., USA, November 15th-16th, 1999 with the participation of representatives from PAHO, WHO, and WHO Collaborating Centers in Traditional Medicine.

- The project "*Frameworks for the Promotion of Indigenous Medicine and Therapies in Primary Health Care,*" formulated in 1999 in response to recommendations from the participants of the PAHO/WHO Working Group.

- Phase I of the project was carried out in 2000. In this phase, five studies were conducted to determine the health care dynamic in specific indigenous communities. The studies were

[6] Pan American Health Organization. *Traditional Health Systems of Latin America and the Caribbean: Core Data.* Health of the Indigenous Peoples Series. No. 13. Washington, D.C., USA. 1999.

[7] The report on the discussions of the Working Group on Human Resources and Cultural Diversity is summarized in: *Incorporating the Intercultural Approach to Health into the Training and Development of Human Resources* . Health of the Indigenous Peoples Series. No. 12.

conducted with the Nahuatl, Pipil, Mapuche, Mayan, Garífuna, Nöbe-Buglé, and Quechua of El Salvador, Chile, Guatemala, Honduras, Panama and Peru, respectively.

- The results of these case studies were presented and discussed in the *Workshop on the Promotion of Indigenous Medicine and Therapies in Primary Health Care in the Americas,* held in Guatemala City, Guatemala, March 21st-22nd, 2001, in which the following representatives participated: indigenous peoples, government agencies, PAHO, nongovernmental organizations, and academics from Bolivia, Chile, Cuba, El Salvador, the United States, Guatemala, Honduras, Jamaica, Mexico, Panama, and Peru. Representatives of the WHO Collaborating Centers in Traditional Medicine were also among the participants.

4. Conceptual Approach to a Holistic Perspective in Health

The conceptual approach presented below seeks to understand the dimensions that come together in the holistic perspective on health. In instrumentalizing this approach, harmonization of the indigenous and conventional health systems is proposed through incorporating indigenous perspectives, medicines, and therapies into primary health care. The discussion is based on pre-existing literature, group discussions that have taken place at various meetings on the topic, and experiences with the implementation of the Health of the Indigenous Peoples Initiative of PAHO and the Member States of the Organization.

Why Harmonization and Why Incorporation?

This document uses the term *harmonization* as a synonym for conciliation, consensus-building, or mediation, and the term *incorporation* as a synonym for association, inclusion, or access (Ortega Cavero, D. 1991; Word-Office, 2000. However, the use of other words to represent the need for collaboration between indigenous health systems and the conventional health system is recognized, making it important to note that a number of these terms may have meanings associated with certain social and historical contexts that are not necessarily optimal for indigenous peoples. For example, the word *integration* as a synonym and euphemism for assimilation is associated with the 1940s trend toward the implementation of policies to improve the living conditions of indigenous populations mainly by assimilating or "integrating" them into the so-called "national society." As Stavenhagen points out, the dominant national society, reflected in the nationalist ideology of the white urban middle and mestizo class, completely rejected the indigenous components of the national culture. In fact, it saw no future for them except as part of an idealized past whose privileged place was either in the museums or as an instrument for procuring foreign exchange from tourism and the sale of handicrafts. In formulating policies on indigenous peoples, indigenous representation was merely symbolic. Though well-intentioned, these policies actually turned out to be ethnocidal (Stavenhagen, 1992).

Table 4 presents some of the terms utilized in different publications on the subject in question. Several synonyms are included.

Table 4: Terms Utilized

Term	Synonyms
Incorporation	inclusion, access, entry, acceptance, association
Integration	union, unification, reunion, combination, equality
Collaboration	contribution, participation, partnership, support, reciprocity, assistance
Articulation	juncture, liaison, link, coupling, union
Harmonization	liaison, conciliation, adjustment, conjunction, union, mediation, consensus-building
Complementarity [8]	supplementary, increased, added, augmented

Source: Ortega Cavero, D. Thesaurus Gran Sopena de Sinónimos y Asociación de Ideas, 1991. Thesaurus, Word-Office, 2000.

Who are we referring to when we talk about indigenous populations and peoples?

The terms utilized to define indigenous peoples vary from country to country, depending on the social and historical contexts as well as the group's language, ancestry, self-identification, and geographical concentration or territoriality (OPS, 1998).

Similarly, the terms used for "indigenous peoples" vary, especially depending on the country in which the peoples are living, for different terms have been used in assigning names to indigenous populations. Examples include: indigenous population, original peoples, and native communities in general; tribes, nations, and native Americans in the United States; ethnic groups in Honduras; ethnic

[8] Although the description of the term complementarity has a sense of subordination, several researchers speak about the principle of complementarity when describing the philosophy of the Andean indigenous peoples. For example, Yánez del Pozo indicates that "the principle of relationality, basis of the rationality or Andean logic, is manifested in a series of secondary principles such as that of correspondence or mutual relation, that of complementarity or inclusion of the opposites and that of reciprocity or of constant compensation. The principle of complementarity speaks about the inclusion of the opposites. Sky and soil, sun and moon, clear and dark, true and falsehood, day and night, good and evil, above and below, cold and hot, masculine and feminine, they are not for the runacuna (Andean people) exclusive contrasts but necessary complements for the assertion of a superior and comprehensive entity" (Esterman 129 in Yánez del Pozo). In contrast, western philosophy, in general, has adopted the principle of dialectics and unilineal progress (Yánez del Pozo, 2002). In this document it is recognized that the meaning of the principle of complementarity deserves to be considered in order to comprehend the effective harmonization of the indigenous health systems and the conventional health system.

groups and first nations in Canada; nationalities in Ecuador; societies in Brazil, and Amerinds in Guyana. Many indigenous peoples demand to be called by their specific names, as is the case of the Maya in Guatemala, the Quichuas in Ecuador, the Tawahca in Honduras, and the Kunas in Panama. Some peoples are in the process of restoring their ancestral names, rejecting the pejorative terms that have been employed to refer to them, such as the Tsáchilas of Ecuador, previously known as Colorados and the Ngöbe of Panama, previously known as Guaymíes.

This text uses the term "people," accepting Stavenghagen's definition, which indicates that:

> The concept of a "people" refers to the features characterizing a human group in territorial historical cultural and ethnic terms that give it a sense of identity (Stavenhagen 1992).

In addition, ILO Convention No. 169 concerning Indigenous and Tribal Peoples in Independent Countries recognizes as indigenous peoples "…peoples in independent countries who are regarded as indigenous on account of their descent from the populations which inhabited the country, or a geographical region to which the country belongs, at the time of conquest or colonization or the establishment of present State boundaries and who, irrespective of their legal status, retain some or all of their own social, economic, cultural and political institutions."[9]

This document accepts the various definitions. In addition, given the general tendency to consider indigenous peoples only as rural populations, it notes the need to recognize the different social, political, and economic phenomena (migration, civil wars, development projects, over-exploitation of natural resources, successive waves of settlers, military incursions due to border conflicts or the repression of subversive or illegal activities) that have caused indigenous populations to relocate outside their ancestral territories.

Over time, the indigenous peoples of the Region have developed a set of practices along with comprehensive and extensive knowledge about the human body and how to live in harmony with other human beings, with nature, and with spiritual beings. The systems they have developed are very complex and in structure as well as in content and internal logic; they are based upon the principles of balance, harmony, and holism (PAHO; 1997). From the perspective of indigenous peoples, health is holistic by nature.

What Elements Comprise the Indigenous Perspective in Health?

According to the World Health Organization (WHO), health is a state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity (OMS, 2001). Indigenous peoples have a holistic view of the world; thus, they define health in terms of complete well-being, which includes the spiritual dimension. For example, at a health workshop in Ecuador in 1995, several indigenous representatives indicated that health/well-being is "the harmony of all the elements that comprise health"; that is, the right to have their own understanding and control over their own

[9] On June 7th 1989, Convention No. 169 of the International Labor Organization (ILO) on Indigenous and Tribal Peoples in Independent Countries was adopted. This was the first document that included the notion of a people as a collective unit, whose principal collective right is territory--understood as the natural, geographical, cultural, mythical, and religious resources that make up its cosmic vision and ensure its survival.

lives, and the right "of human beings to live in harmony with nature, with themselves, and with each other to achieve complete well-being and individual and collective spiritual fulfillment and peace." When the indigenous leaders of the Salvadorian National Indigenous Coordinating Board (CCNIS, 2000) were asked what health is, they said the following: "We indigenous people consider ourselves to be an indivisible body and soul; we are in balance with our family and work environment through our ancestral wisdom; this helps us to live in harmony with the living elements of the universe: plants, animals, land, fire, air, and water. For us, this is health and well-being."

In other words, by incorporating several paradigms based on indigenous perspectives, health finds expression through the dynamic relationships and equilibrium among the inseparable components of the individual (physical, mental, emotional, and spiritual) and the collective (ecological, political, economic, cultural, social and, once again, spiritual). This holistic conception of health encompasses the biological, psychological, social, and spiritual well-being of an individual and his or her social community under conditions of equity.

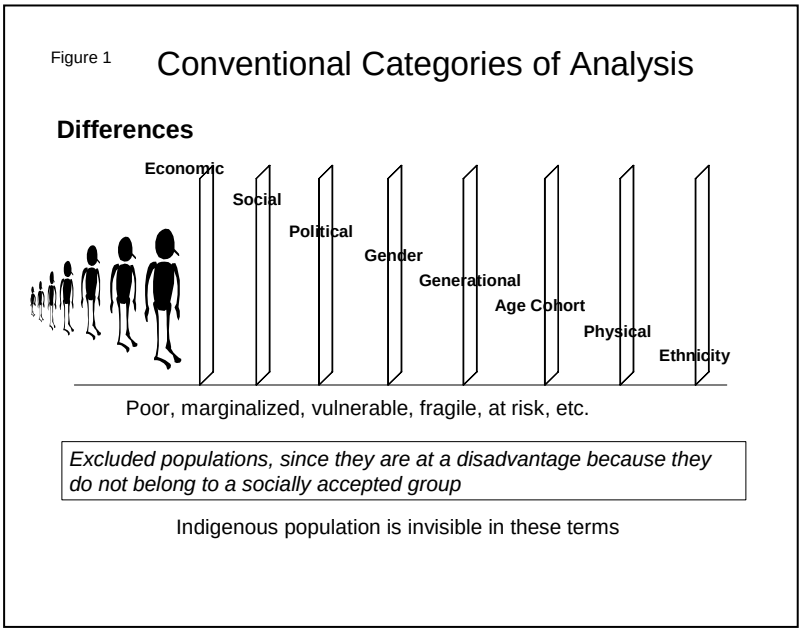
This conceptual view, which is presented below, takes into account the special social, economic, cultural, demographic, and political features of populations. Although this discussion refers to the specific case of indigenous peoples, it could be applied to other excluded populations. This conceptual reflection, which attempts to show the correlation between different variables as well as the cumulative impact of different variables, will, henceforth, be defined as Sociocultural Analysis.

4.1 Sociocultural Analysis

From a conventional standpoint, when describing a marginalized population's living conditions and health status there is a tendency to emphasize what is lacking. Although demographic, socioeconomic, morbidity, mortality, resource, access, and coverage indicators are useful and necessary; they tend to homogenize different and distinct populations and fail to consider the populations' individual capacities or perspectives. Sociocultural analysis, applied to indigenous peoples, starts with official recognition of and respect for indigenous peoples.

If we review conventional analyses, we notice that different population groups are usually classified on the basis of parameters that, like filters, break the population down into different categories and subcategories (Figure 1).

Figure 1



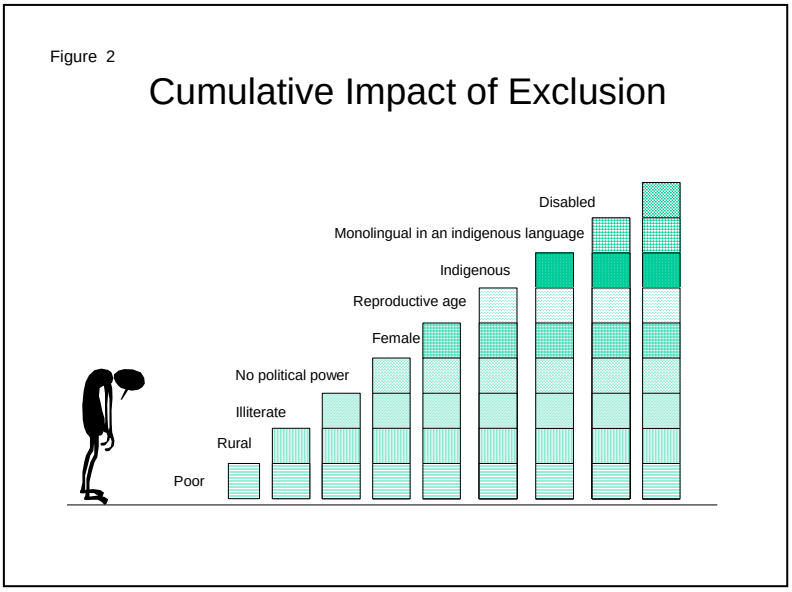
The filters used in these conventional analyses classify people as poor, marginalized, vulnerable, fragile, at risk, etc., terms that make the indigenous populations invisible. This document, when describing population groups (among them indigenous peoples), has adopted the term "excluded populations," since these groups are at a disadvantage because they do not belong to the dominant, socially accepted group (Figure 1) (Rojas, R. Suqair, N., 1998).

According to the criteria governing health sector reform in the countries of the Americas, equity comes with certain requirements: a) in health conditions, equity means reducing avoidable and unjust differences to the minimum possible; b) in the health services, equity means receiving care according to need and contributing economically according to the ability to pay (Whitehead, M. 1990, in PAHO, 1997).

In sociocultural analysis, when speaking about equity we must recognize that for this concept to be applied, we must consider the different characteristics that result in the exclusion of a population group (Figure 2). Among these are poverty, educational level, gender, age cohort, ethnicity, monolingualism in an indigenous language, and physical disabilities.

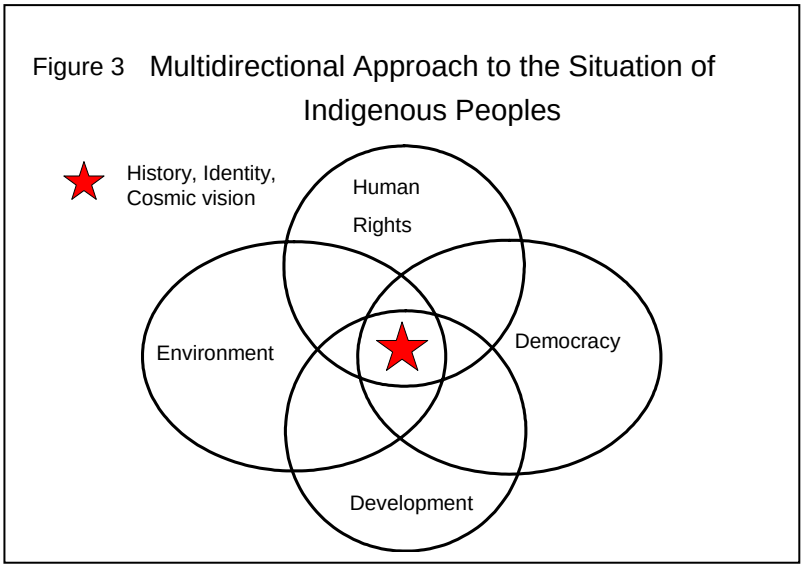
These characteristics, developed in different ways, reinforce one another and create a vicious circle manifested in the exclusion of a specific group. For example, the exclusion would be extreme in the case of a poor, illiterate woman of reproductive age who is indigenous, monolingual in an indigenous language, and disabled (Rojas, R. Suqair, N., 1998) (Figure 2).

Figure 2.



Analysis of the situations that indigenous groups face occurs at the intersection of many areas, including human rights, democracy, development, the environment, in addition to the comprehension of indigenous culture, identity and cosmic vision based on a new approximation to history (Figure 3). In practice, addressing the determining factors of exclusion requires the existence and application of legal frameworks that prioritize the development of these peoples and the consolidation of intra and inter-sectoral cooperation processes.

Figure 3

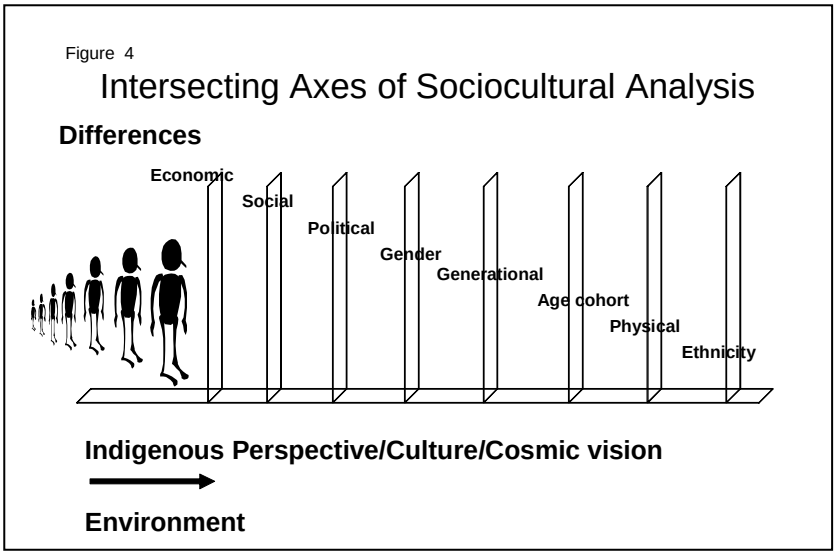


In practice, addressing these exclusion determinants requires the existence and application of legal frameworks that give priority to the development of these peoples and the consolidation of multidisciplinary intra- and intersectoral joint cooperation processes.

Sociocultural analysis involves recognition of the multilingual, multi-ethnic, and multicultural nature[10] of the population of the Region of the Americas and, specifically, of indigenous and other peoples.

This recognition requires including the indigenous perspectives/cultures/cosmic visions [11] of these peoples in the analysis of living conditions and health status and in the formulation of strategies to meet their needs. Understanding indigenous people's respective histories, lifestyles, and contributions to society is therefore indispensable both for the indigenous and non indigenous populations (Figure 4). Incorporating the perspectives of different peoples, in this case indigenous peoples will make it possible to utilize available institutional and community health resources.

Figure 4



Similarly, the environmental conditions under which the daily life of the population unfolds must also be considered an intersecting axis. Certain factors such as climate and lifestyles result in additional risks to the population, e.g. indigenous peoples living in areas endemic to malaria as well as indigenous peoples living in urban slums.

[10] *Multiculturalism* is defined by social realities and consists of the presence within a society of various cultures, indigenous peoples, and ethnic communities as groups with different cultural codes, starting out with the fact that they have different customs and habits (Cunningham, 1999).

[11] *Culture* can be defined as a pattern of beliefs, thought, values, practices, communication, behavior, and institutions (family, religious, economic, and political) that are characteristic of and used to preserve a particular social group. Ethnicity, race, and socioeconomic levels in various combinations shape the different cultural contexts (Cross N, Bagron, Dennis, and Isaacs, 1989), to which it is necessary to add geography. The cosmic vision is a conceptual area in itself. It requires a series of elements that determine the way in which different cultures understand the world and their place in it. In the case of indigenous peoples, the cosmic vision defines the relationship between an individual and other individuals as well as between an individual and society, nature, and spiritual being. The cosmic vision is based on balance, harmony, and a holistic approach (OPS, 1997).

Incorporating the indigenous perspective demands a review of the conceptual frameworks and methods used in working with these communities. These frameworks and methods require the generation of new and complementary paradigms that will make it possible to understand the significance that the indigenous peoples attribute to development, health, disease, social participation, poverty, etc. For example, in conventional analyses, poverty or wealth has been defined in economic terms. If we review the definition of wealth/poverty from the indigenous perspective, we see that wealth constitutes the cultural and linguistic potential, the capacity for social control and leadership, access to the land and the different ecological systems, the link with community power, and adherence to community principles such as solidarity and reciprocity. In this view, a person would be considered to be poor if he or she does not meet these requirements even if he or she is economically rich (Pacari, N. 1996).

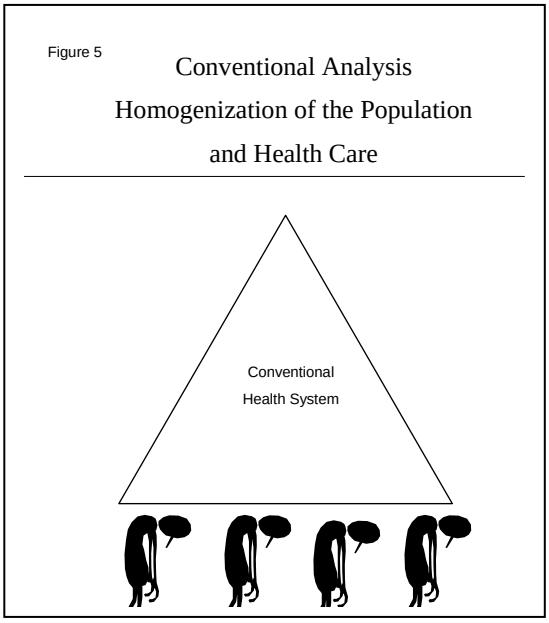
4.2 Application of Sociocultural Analysis to Health Systems and Services: the Intercultural Approach to Health

In health care, sociocultural analysis promotes an intercultural approach to health. Sociocultural analysis encompasses the characterization of different population groups, community resource utilization, and an understanding of indigenous health systems12, which are based on beliefs and values systems that determine the maintenance and restoration of health.

Conventional analyses, in general, tend to homogenize the population and to consider the health system a closed system, a system solely based on the biomedical principles of conventional/western medicine (Figure 5).

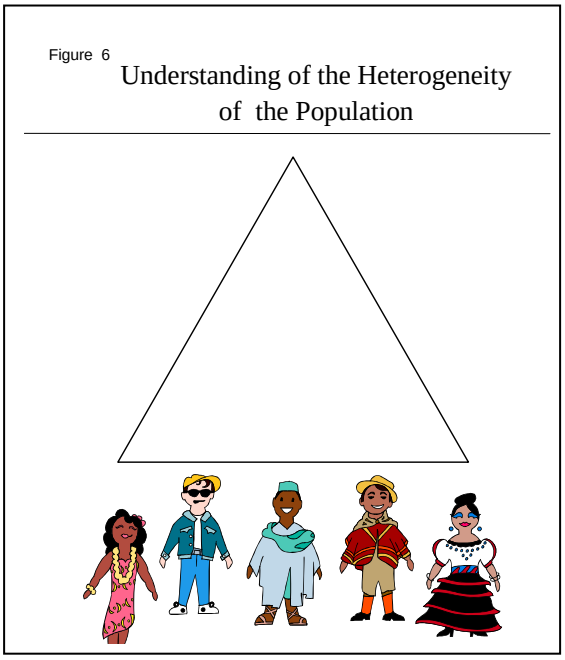
[12] Local health systems are the complex set of processes that constitute the totality of social action in health at the local level, including, but not limited to, health service delivery (OPS, 1993). Thus, traditional/indigenous health systems are a particular type of local health system characterized by the concepts of all-inclusiveness and the holistic approach that have both been ever-present among indigenous peoples (Yánez del Pozo, 2000).

Figure 5



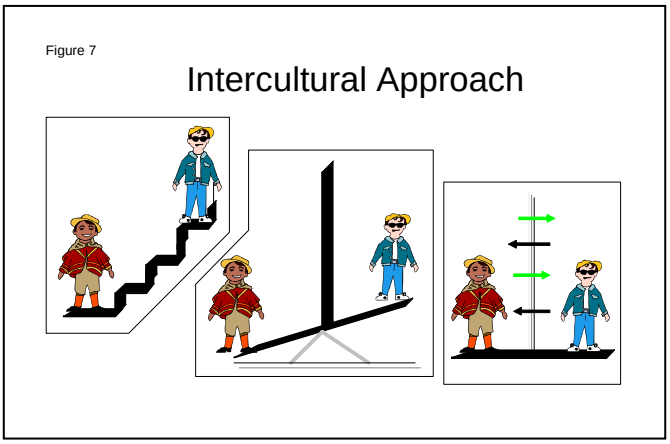
In sociocultural analysis, the intercultural approach to health recognizes the importance of characterizing the population and understanding the dimensions of ethnicity, culture, and the cosmic vision of peoples, especially in relation of the health dynamics of the particular group (Figure 6).

Figure 6



Sociocultural analysis stresses the importance of knowing past and present historical processes that have engendered different levels of "prestige" among cultures in addition to asymmetrical relations that have given rise to barriers of mistrust and fear (Figure 7).

Figure 7



In instrumentalizing the intercultural approach to health, the concept of cultural diversity involves equitable relations that respect political, economic, social, cultural, age, linguistic, gender, and generational differences--relations established in a particular location between and within different cultures and ethnic groups in order to create a just society (OPS, 1998b). In practice, the intercultural approach to health poses the challenge of creating opportunities for dialogue between different cultures that will empower excluded peoples and raise awareness among privileged groups (Figure 7).

When describing the organization and operation of health services, what is usually mentioned are the facilities and resources of the public sector (Ministry of Health, Social Security Institutes, Ministries of Defense, Ministries of Welfare, municipalities, police, etc.) and the private sector (private establishments, churches, nongovernmental organizations, foundations, etc.). The care provided by these facilities is, for the most part, grounded in the biomedical principles of conventional/western medicine. Although traditional, alternative, and complementary therapies and medicines have gained ground in several countries, very few countries even consider indigenous therapies and medicines as part of the health sector[13]. The strategies the population employs to maintain and restore health in the home or the community are ordinarily not included among the health resources of the general population. In this context, the intercultural approach to health constitutes one of the instruments for putting into practice the concept of health promotion so that it may be employed as one of the strategies to provide the peoples with the means necessary to improve their health and have greater

[13] *Traditional medicine and therapies* constitute the knowledge about health that originated long before the development and spread of conventional/western medicine and knowledge. They reflect the culture, history, and beliefs of a country and, obviously, have undergone changes with the passage of time. This knowledge is usually transmitted orally from generation to generation (OPS, 1999). Indigenous medicines and therapies are traditional medicines and therapies. In most countries where western medicine assumes full responsibility for health care in the national arena, the majority of traditional medicines and other therapies are considered complementary or alternative to conventional institutional health systems (OPS, 1999). In some areas, indigenous medicines and therapies are complementary; in others, alternative, and in still others, they are the only permanent health resource.

control over their lives[14]. In this context, health is perceived not as the object of but as the source of wealth in their daily lives.

In the health care dynamic, the intercultural approach recognizes the existence of both "formal" and "informal" health systems that, in practice, are linked [15] (Figure 8). This linkage is not necessarily created by the conventional referral and counter-referral systems but by the population's preferences as well as its access to each of these systems. When evaluating access to health care and health care coverage, the social, economic, and cultural characteristics that determine the attitudes, knowledge and practices of the population must be taken into account. In this perspective, understanding the sense of belonging that indigenous persons have not only to a community but also to a specific people, is relevant.

Figure 8

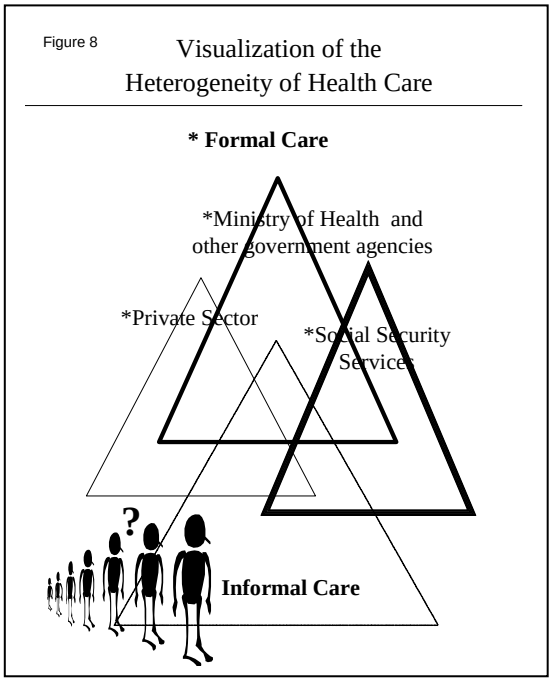
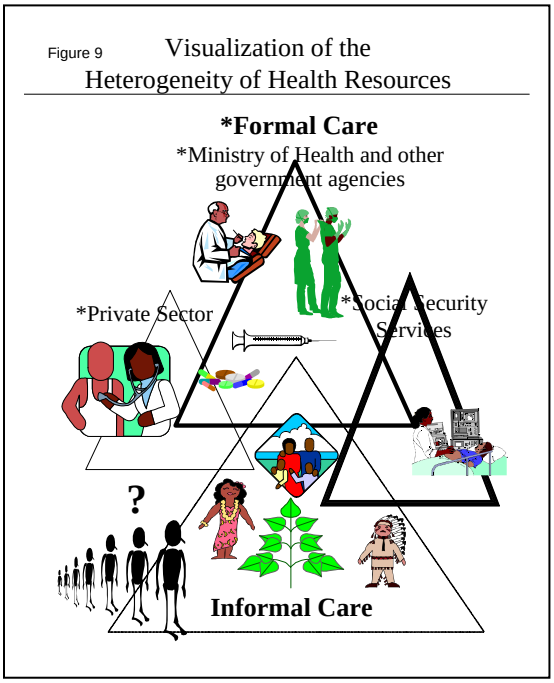


Figure 9



In this context, the intercultural approach to health involves the recognition of human resources, of therapeutic resources, and of strategies that extend beyond the conventional health

[14] The Ottawa Charter for Health Promotion was issued by the International Conference on Health Promotion in response to the growing demand in the public health world (OPS. 1996a).

[15] Traditional medicine constitutes one of the three basic models; the others are academic medicine and domestic or home medicine, which make up the real health care system in the majority of Latin American countries (Instituto Nacional Indigenista, 1994). The formal health system is based on biomedical principles. Among the informal health systems are the indigenous health systems and the wisdom of popular or domestic medicine. "Popular or domestic medicine" is the resources available to the population to meet some of its health care needs. Unlike indigenous health systems, these resources and knowledge are not limited to a specific cosmic vision but consist of knowledge taken from different types of medicine (allopathy, traditional medicine, etc.). Popular medicine is usually practiced in the home or as a first line of action before consulting a physician or therapist (OPS, 1999).

system's paradigms (Figure 9). For example, while the term "health care provider" in conventional health systems include physicians, nurses, laboratory technicians, dentists, health promoters, etc., in indigenous health systems, the *yachas, sukias, pajuyucs (healers from Andean, Afro-Caribbean, and Amazonian cultures), machis spiritual healers from the Mapuche culture), midwives, bonesetters, shadow callers, herbalists,* etc., appear in the list of health care providers[16]. While the therapeutic arsenal in the conventional health system includes pills, surgical procedures, intravenous administration of drugs, etc., indigenous health systems use plants, stones, rituals, and ceremonies to help maintain or restore health.

In practice, probably due to the lack of a specific methodology, analogies are often used to understand the structure of indigenous health systems, comparing their elements with those of the conventional/western health system. Thus, when describing indigenous health systems, it is said that indigenous health systems include the entire body of ideas, concepts, beliefs, myths, procedures and rituals (whether explainable or not) connected with the maintenance of health or health restoration through the treatment of physical and mental illness or social imbalances in a particular individual, community, or people. This body of knowledge, grounded in the people's cosmic visions, explains the etiology, nosology and procedures for the diagnosis, prognosis, cure, disease prevention, and health promotion (Valdivia, 1986; OPS, 1997; Yánez del Pozo, 2001).

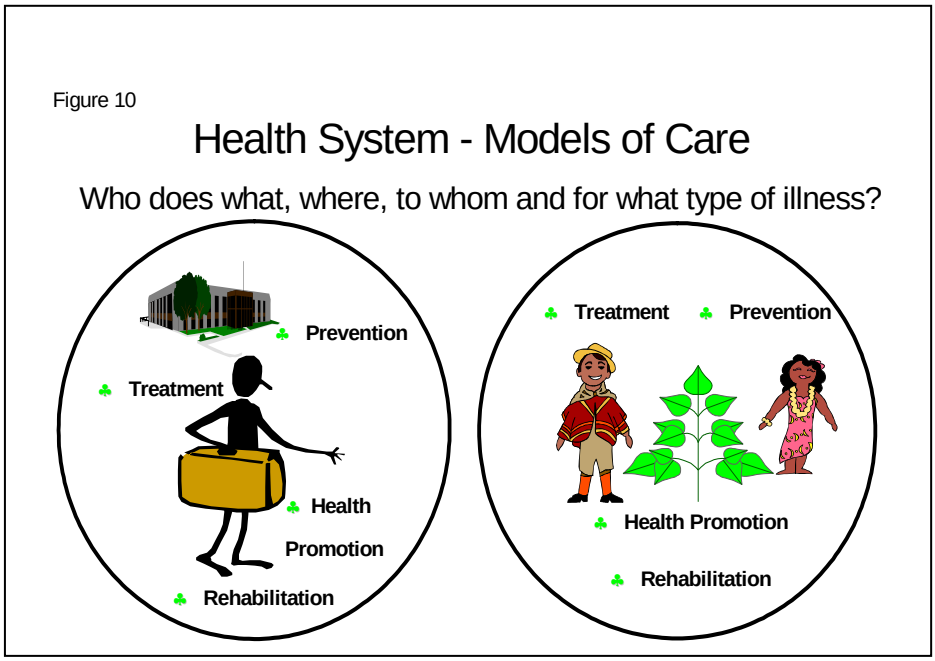
Like the conventional health system, indigenous health systems have treatment, disease prevention, rehabilitation, and health promotion strategies. They also have human resources, infrastructure, and inputs that form part of a unique structure and logic (Figure 10). However, the availability of the conventional and indigenous health system varies depending on geography, population type, the preferences of those involved in the health systems, and the epidemiological profile that follows specific cultural codes.

After recognizing the existence and the interaction of the conventional and indigenous health systems, the intercultural approach to health seeks to improve knowledge about the resources of these systems and take greater advantage of such knowledge and resources (Figure 10).

The formulation and implementation of models of care consistent with the population's social, cultural, and epidemiological characteristics depends on our responses to this question: **Who does what, to whom, for what type of illness, and where?** The responses to this question should be considered in light of both the populations' health care needs and the perception of quality on the part of the users of these systems (Figure 10).

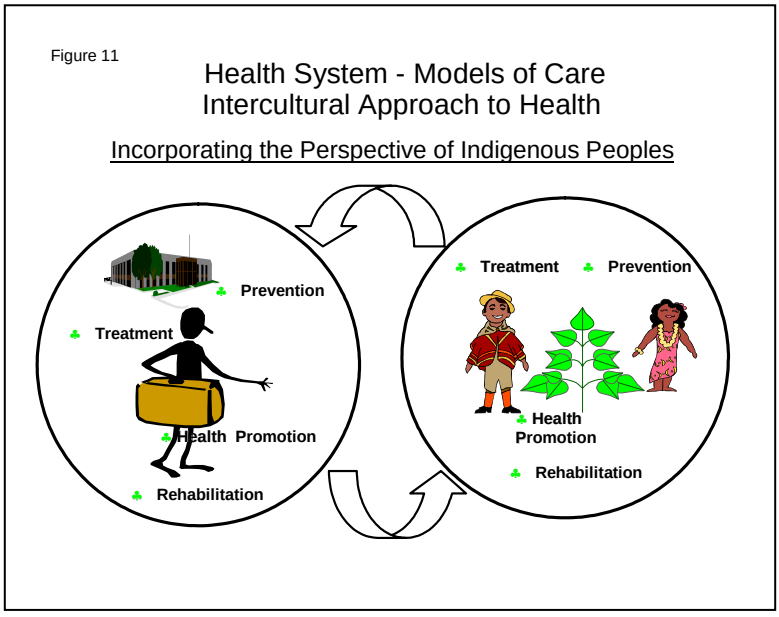
[16] Referring to people who are able to cure, a respected elderly person who is a shapori (shamán) yanomami in Venezuela indicated, "there are diseases that a physician can not cure and are cured by the shapori; there are diseases that the shapori can not cure and are cured by the physician; and there are diseases that can not be cured by the physician nor by the shapori.." The observation reflects a relation of respect that values identity and recognizes "the other one." There should not be a competitive relationship among health workers and traditional healers. To cure diseases is not the responsibility of the shaman. His/her scope of action includes a relation with the cosmos and with the natural and social order of his/her community. Within this scope, disease is a very small area (Sánchez-Salame, G; 2002).

Figure 10



In practice, the intercultural approach involves the harmonization of indigenous health systems with the conventional health system, incorporating indigenous perspectives, medicines, and therapies into the national health systems. Incorporating indigenous perspectives requires setting up and implementing legal frameworks that prioritize care for indigenous peoples. It also demands an understanding of the components and response capacity of the different health systems, as well as the knowledge, attitudes, practices, connotations, and perceptions of the health care users (Figure 11). The intercultural approach makes it possible to adapt conventional health programs to community realities.

Figure 11

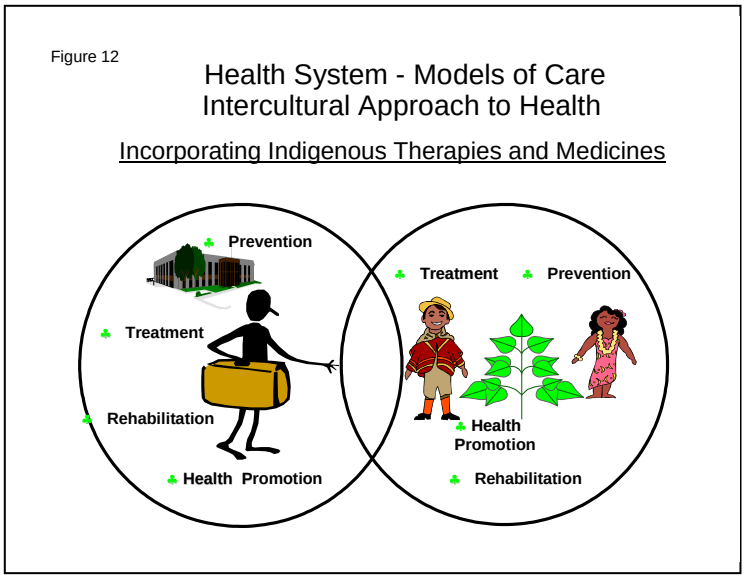


Incorporating indigenous medicines and therapies into national health systems requires setting up and implementing a **legal framework** that permits social participation, the use of indigenous medicines and therapies, and the recognition, protection and preservation of community knowledge and resources. It also involves **generating knowledge and paradigms** that broaden conceptual frameworks and promote an understanding of indigenous knowledge and its incorporation into **human resources training and development.**

Employing an intercultural approach to health as part of the strategies to promote the social, economic, political, and human development of indigenous peoples involves harmonizing indigenous health systems with the conventional health system by incorporating indigenous perspectives, medicines, and therapies. This approach poses the challenge of finding unity while at the same time acknowledging the diversity of peoples.

Incorporating indigenous health systems' knowledge, resources, and practices must be combined with the organizational processes of indigenous peoples, the protection of ecosystems and sacred places, the guarantee of justice and legislative protection, programs to promote health and social well-being, the strengthening of indigenous cultures, and the search for new ways of linking indigenous healers and community health workers with the State (Instituto Nacional Indigenista, 1994). Developing strategies that facilitate this incorporation involves three main areas of action within a context that fosters cultural diversity: 1) the harmonization of laws; 2) the harmonization of concepts; and 3) the harmonization of practices (Figure 12).

Figure 12



5. Strategies for Incorporating Indigenous Perspectives, Medicines, and Therapies into Primary Health Care

The sections below summarize each area of action, describe the progresses and challenges, and identify the monitoring and evaluation indicators used in implementing the strategies proposed.

The strategies are based on the findings of six case studies that analyzed the indigenous health systems in Chile, El Salvador, Guatemala, Honduras, Panama, and Peru, on several studies conducted in different countries, on the experience gained in the implementation of the Health of the Indigenous Peoples Initiative, and on the processes under way in the Region of the Americas.[17]

5.1 Harmonization of Laws

Harmonization of laws is a process in which legal frameworks–policies, laws, regulations, and standards—are adapted to the social and cultural characteristics of indigenous peoples. It is a process aimed at establishing an equitable relationship between indigenous peoples and the national society. In the specific area of health systems and services, it requires the creation of legal frameworks that facilitate access for the indigenous population to quality health care and officially recognize the contribution of indigenous health systems to the maintenance and restoration of the population's health.

Progress

The countries of the Hemisphere have signed and ratified a variety of declarations, agreements, resolutions, and international treaties to benefit indigenous peoples. The mechanisms for incorporating them into the national legal framework vary,[18] as does the degree of implementation.

With regard to the general and specific directives to incorporate, indigenous perspectives, medicines, and therapies into health care, there is Convention 169 concerning Indigenous and Tribal Peoples in Independent Countries of the International Labor Organization (ILO) and Resolutions CD37.R5 and CD40. R6 of PAHO (Table 5 and 6).

[17] In addition to the documents cited, which are contained in the References Section of this document, the collection database of the Health of the Indigenous Peoples Initiative contains publications that make important contributions to the discussion at hand and may be of interest to the reader. This collection is not exhaustive; there are many published and unpublished studies and experiences in the Americas.

[18] There are three modalities for incorporating international law into domestic law based on three theories: 1) Transformation theory: international law must be transformed into national law; 2) Implementation theory: a domestic act is required, and the international law is not transformed but remains as international law; 3) Incorporation theory: international law is immediately transformed in national law. Under the three modalities, international law always has primacy (Mello, 1997).

Table 5: Convention 169 of the ILO – Part V. Social Security and Health

Article 24

Social security schemes shall be extended progressively to cover the peoples concerned and applied without discrimination against them.

Article 25

1. Governments shall ensure that adequate health services are made available to the peoples concerned or shall provide them with resources to allow them to design and deliver such services under their own responsibility and control, so that they may enjoy the highest attainable standard of physical and mental health.

2. Health services shall, to the greatest extent possible, be community-based. These services shall be planned and administered in cooperation with the peoples concerned and take into account their economic, geographic, social and cultural conditions as well as their traditional preventive care, healing practices and medicines.

3. The health care system shall give preference to the training and employment of local community health workers and focus on primary health care while maintaining strong links with other levels of health care services.

4. The provision of such health services shall be coordinated with other social, economic, and cultural measures in the country.

Table 6: Resolutions CD37.R5 and CD40.R6 – Selected Articles

Resolution CD37.R5-PAHO	**Resolution CD40.R6-PAHO**
2. To urge the Member Governments: (b) To strengthen the technical, administrative, and managerial capacity of national and local institutions that are responsible for the health of indigenous populations with a view to progressively overcoming the lack of information in this area and ensuring greater access to health services and quality care, thus contributing to a higher degree of equity; (d) To promote the transformation of health systems and support the development of alternative models of care, including traditional medicine and research into quality and safety for indigenous populations within the local health system strategy.	Resolves: ▪ To urge the Member States, in the process of the implementation of health sector reform, to be persistent in efforts to detect, monitor, and reverse inequities in health status and access to basic health services for vulnerable groups, including indigenous peoples. ▪ To call to the attention of Member States that renewal of the goal of health for all requires that sustainable solutions are found to address the economic, geographic, and cultural barriers to adequate care for vulnerable groups.

Convention 169 of the ILO has been ratified by Argentina, Bolivia, Colombia, Costa Rica, Ecuador, Guatemala, Honduras, Mexico, Paraguay, and Peru. Resolutions CD37.R5 and CD 40. R6

have been ratified by all the Member States of PAHO.[19] Implementation of these international and national legal frameworks in the countries of the Region has resulted in constitutional reforms in Bolivia, Colombia, Ecuador, Mexico, Nicaragua, and Paraguay. Table 7 offers examples of constitutional articles recognizing the cultural diversity of national populations.

Table 7: Examples of Constitutional Articles Recognizing the Cultural Diversity of National Populations

Bolivia	**Article 1:** Bolivia, free, independent, sovereign, multi-ethnic and multicultural, constituted as a unitary Republic, adopts for its government the democratic representative form, based on the unity and solidarity of all Bolivians.
Colombia	**Article 7**: The State recognizes and protects the ethnic and cultural diversity of the Colombian Nation.
Ecuador	**Article 1:** Ecuador is a social state of law that is sovereign, unitary, independent, democratic, multicultural, and multi-ethnic. Its government is republican, presidential, elective, representative, responsible, alternative, [and] participatory, with a decentralized administration. The State respects and promotes the development of all Ecuadorian languages. Spanish is the official language. Quichua, Shuar, and other ancestral languages are for official use for indigenous peoples, under the terms established in the law.
Mexico	**Article 4:** The composition of the Mexican nation is multicultural, rooted in its original indigenous peoples. The law shall protect and promote the development of their languages, cultures, mores, customs, resources, and specific forms of social organization and guarantee effective access by the members of these peoples to the jurisdiction of the State. In agrarian lawsuits and proceedings to which they are parties, their judicial practices and customs shall be taken into account under the terms established in the law. Men and women are equal under the law. This will protect the structure and development of the family.

Source: Georgetown University. Constituciones Políticas. Base de Datos Políticos de las Américas. http://www.georgetown.edu/LatAmerPolitical/Constitutions/constitutions.html

Moreover, these guiding principles have supported the formulation of laws, programs, and models that, through specific technical units responsible for the health of indigenous populations, attempt to address the needs of these peoples.[20] This is true in Argentina, Bolivia, Brazil, Canada, Chile, Colombia,[21] Ecuador, El Salvador, Guatemala, Honduras, Panama, and the United States. Several of these countries make indigenous medicine one of their priorities, while others have laws, plans, and specific technical units to deal with this area. Examples include the Institute of Traditional Medicine of the Ministry of Health of Peru; Resolution 10013 of Colombia; the Policies and Strategies 2000-2004 of

[19] PAHO has 35 Member States: Antigua and Barbuda, Argentina, Bahamas, Barbados, Belize, Bolivia, Brazil, Canada, Chile, Colombia, Costa Rica, Cuba, Dominica, the Dominican Republic, Ecuador, El Salvador, Grenada, Guatemala, Guyana, Haiti, Honduras, Jamaica, Mexico, Nicaragua, Panama, Paraguay, Peru, St. Kitts and Nevis, Saint Vincent and the Grenadines, Saint Lucia, Suriname, Trinidad and Tobago, the United States of America, Uruguay, Venezuela.

[20] The Annex contains eleven examples of national legal frameworks that promote health care for the indigenous peoples of the Americas.

[21] In Colombia, legislation has facilitated the formulation and implementation of a model of care designed for the indigenous peoples of the Department of Vaupés (Guevara G., J. 1998).

the Ministry of Health of Panama, and Executive Decree 194 of August 26, 1999, adopting the Organic Administrative Charter of the Ngöbe-Buglé Region of Panama. Table 8 provides details of the examples cited.

Table 8: Examples of Directives that Promote the Incorporation of Indigenous Perspectives, Medicines, and Therapies into the National Health Programs

Resolution 10013 of Colombia establishes that primary health care programs for the indigenous population shall be adapted "to the organizational, political, administrative, and socioeconomic structure", so that "their values, traditions, beliefs, attitudes, and cultural heritage are respected;" that such programs should be preceded by studies that will make it possible "to understand the cultural, socioeconomic, and health situation" of the indigenous population and "its mythical concept of health and disease;" that, with the support of such studies; models shall be prepared that will make it possible "to provide efficient primary care services" and establish how to integrate traditional indigenous medicine into institutional medicine (Roldán Ortega, R. 2000).
In *Health Policies and Strategies 2000-2004 of the Ministry of Health of Panama*, the strategy of the new orientation in health policy targeted at indigenous populations is "to adapt health programs in indigenous regions to the cultural patterns of the different ethnic groups." This orientation includes the "preservation of traditional medicine and links with midwives and traditional healers" (OPS-Estudio de Caso Panamá, 2000).
Article 256 of *Executive Decree 194* from August 26, 1999, adopting the Organic Administrative Charter of the Ngöbe-Buglé Region of Panama, includes the "Office of Traditional Medicine" under the Comarcal Medical Bureau. Article 257 creates the Specialized Technical Medical Commission of the Comarca for the purpose of "harmonizing and fusing western with traditional medicine." Articles 261 and 262 refer to the "creation of orchards and botanical gardens to establish a natural science laboratory in which plants should be classified by their species and purpose, as should medicinal products of animal origin," and this classification shall be published in "texts and health manuals for its perpetuation" (OPS-Estudio de Caso Panamá, 2000).
In Guatemala, *Peace Agreements* specify the Agreements on Identity and Indigenous Peoples' rights in numeral 8.1. With regard to Regionalization, Chapter IV, literal C states that "considering that the administrative regionalization is based on a profound decentralization and deconcentration, whose configuration reflects economic, social, cultural, linguistic and environmental criteria, the Government is committed to regionalizing the management of education, health and cultural services of the indigenous peoples according to linguistic criteria." Agreements on Socioeconomic Aspects and Agrarian Situation are in numeral 8.2. Chapter I, literal A, paragraph 10, literal e, states "to regionalize health, education and cultural services of indigenous peoples and to ensure the full involvement of the indigenous organizations in the design and implementation of this process." In the section on *Health* regarding *indigenous and traditional medicine*, the document states, "Recognizing the importance of indigenous and traditional medicine, research studies will be promoted and its conceptions, methods and practices will be recovered." With regard to the specific *Social Involvement* the Agreements indicate "to promote the active involvement of the municipalities, the communities, and the social organizations (including women, indigenous population, civic and humanitarian unions) in the planning, execution, and management control of the health services and programs, through the local health systems and the Urban and Rural Development Boards."

Challenges

Although progress has been made in harmonizing legal frameworks and examples, which constitute an important reference point for legislative development, challenges remain that must be addressed.

- The international legal framework, especially ILO Convention 169 and the directives of Resolutions CD37.R5 and CD40.R6 of PAHO, establish guidelines to facilitate the incorporation of indigenous perspectives, medicines, and therapies into primary health care. However, their implementation in the countries of the Region has not moved forward as expected.

- Some countries have not yet officially recognized the multi-ethnic, multilingual, and multicultural nature of their national population.

- Although countries have granted official recognition to indigenous peoples, their ancestral knowledge and curative resources have, in practice, been separated from the cultural context and cosmic vision of these peoples. In many cases, a utilitarian approach towards the use of indigenous knowledge has been taken, which has not benefited indigenous peoples.

- Lack of clarity with regard to the legal status of indigenous medicines and therapies impedes the development of policies and standards consistent with their essence. In this regard, two positions are currently in debate in the countries of the Region. One advocates the *legitimization* of indigenous medicine and therapies, creating the conditions for the development of this knowledge. The other supports *legalization,* creating the conditions for legal recognition of indigenous medicines and therapies (Saltos Galarza, N. 1995; Campos Navarro, L. A., 1996). Here, debate on collective intellectual property rights and the protection and conservation of biodiversity and indigenous knowledge is indispensable. The promotion of joint discussions with the full participation of indigenous peoples will make it possible to determine the most suitable mechanisms for official recognition of indigenous knowledge, resources, and therapies.

- Examples can be found in the Americas in which indigenous organizations constitute an important social movement in a country. However, in general, the disproportionate representation and legitimacy of participation by indigenous people and their organizations continue to pose a challenge in decision-making and executive bodies.

- The indigenous peoples' ongoing struggles for recognition of their rights have been of indisputable importance in the legislative advances that promote the development of indigenous peoples (e.g. education and land ownership). However, health, in terms of access to quality care and recognition of their knowledge contributions to the health of the population, still has low priority on the agendas of indigenous organizations.

Harmonization of Laws: Strategies and Process Indicators	
Strategies	**Process Indicators**
▪ International agreements, declarations, and resolutions establish common guidelines that facilitate the identification of priorities and strategies to address common problems. In this regard, referring to the fulfillment of the present international commitments in the Convention 169 of the ILO and particularly Resolutions CD37.R5 and CD40.R6 of PAHO, it is necessary to promote communication and coordination mechanisms that facilitate both cooperation among international organizations and countries, and the dissemination of information with regards to the experience gained in improving care for indigenous peoples.	▪ Number of countries that submit progress reports on the implementation of Resolutions CD37.R5 and CD40.R6, particularly the articles referring to the incorporation of indigenous medicine into alternative models of care and to addressing the cultural barriers that impede access to government-sponsored health care. ▪ Number of national and local projects and projects for technical cooperation among countries that promote the harmonization of indigenous health systems with the conventional health system. ▪ Incorporation of indigenous perspectives, medicines, and therapies into policy agendas, organization agendas, and the agendas of international cooperation agencies--for example, national governments; state, departmental, or local governments, agencies of the United Nations system, International Parliaments, etc.
▪ Official recognition of the existence and importance of indigenous peoples is indispensable for developing strategies that permit the incorporation of indigenous perspectives, medicines, and therapies within the context of respect for the culture, cosmic vision, language, and history of indigenous peoples. Thus, it is essential to facilitate coordination between the executive, legislative, and judicial branches of government and other interested sectors with representatives of indigenous peoples to create the conditions for the review and/or formulation and/or implementation of legal frameworks that facilitate the harmonization of indigenous health systems with the conventional health system.	▪ Constitutional principles dedicated to the recognition of the multi-ethnic, multicultural, and multilingual nature of the national population and, in this context, recognition of indigenous peoples, their culture, cosmic vision, and ancestral knowledge. ▪ Countries present a position paper on the legitimization or legalization of indigenous medicine and therapies, collective intellectual property rights, and the conservation and protection of biodiversity and indigenous knowledge.

Harmonization of Laws: Strategies and Process Indicators (Cont.)	
Strategies	**Process Indicators**
▪ Active, systematic participation by indigenous peoples in the opportunities for consensus-building and decision-making, through their representatives will determine the legitimacy and "ownership" of the processes that involve them. In the area that concerns us, the intervention and assistance of indigenous healers and of indigenous users of the different health systems is especially important. Thus, it is essential to promote actions that, while strengthening and implementing the organizational processes of indigenous peoples, broaden the opportunities for consensus-building and negotiation within the government agencies responsible for improving health care.	▪ Technical commissions, technical units, study groups, and/or internal interprogram commissions in the ministries of health, Parliaments, and other government agencies that have indigenous members and participants. ▪ Number of associations of indigenous healers with ties to conventional health systems and services ▪ Indigenous organizations with health on their agendas

5.2 Harmonization of Concepts

Harmonization of concepts is a process geared towards recognizing indigenous knowledge, practices, and health resources as health systems as well as towards the generation of new and alternative paradigms that make it possible to understand the complexity of the material and symbolic wealth of the theory and practices that indigenous health systems have for maintaining and restoring health[22]. It is the generation of conceptual frameworks, instruments, and methodologies that will contribute to an analysis by contrasting the general theory and perspectives with the particular situation of indigenous peoples and, more particularly, with a specific community or group of communities.

[22] There is a general tendency to reduce the contributions of indigenous health systems to the curative strategies represented by medicinal plants. Not withstanding the invaluable ethnobotanical knowledge of indigenous peoples, including their contributions to the conventional pharmacopeia, it is important to underscore that, in addition to medicinal plants, indigenous health systems have curative resources and strategies for disease prevention, rehabilitation, and health promotion based on a holistic perspective. Thus, the conceptual approach will consider the study of medicinal plants and other therapeutic resources within the context of the culture and cosmic vision of the indigenous peoples and as a strategy for the development of these peoples in addition to the improvement of the health and living conditions of all peoples.

Progress

Recognition of the limitations of the conventional health system and the rising concern about meeting the needs of excluded populations—among them indigenous populations, located primarily on the outskirts of cities and in scattered rural villages—has led the countries to promote activities in order to understand health problems in their particular contexts. Interdisciplinary collaboration between the health and social sciences has generated growing interest in anthropological, ethnographic, and ethnobotanical research applied to the work in health, leading to the broadening of conceptual frameworks.

The global trend toward the humanization of medical practice and the use of alternative complementary therapies and medicines has facilitated the consideration of dimensions in health foreign to the conventional perspective—for example, the social, emotional, and spiritual dimensions of indigenous medicine that promotes the individual and collective well-being. In this context, indigenous peoples play an essential role in sensitizing government agencies, academic institutions, and the general public to the existence of "other" paradigms, concepts, and ways of viewing the world.

Based on the conceptual progress stemming from the findings of the case studies on indigenous medicine,[23] and keeping in mind that processes differ from country to country, it is clear that indigenous peoples share a common cosmic vision that basically views health as the equilibrium between natural and spiritual forces, between individuals and communities, and between social and political factors. In this view, disease is an alteration of the equilibrium. However, indigenous peoples and their concepts do not live in isolation. Side by side with the diseases of cultural etiology are the imbalances produced by causes understood in the conventional paradigms as deficiencies, microorganisms, organic processes, and the factors related to the societies involved. In restoring balance, many of the studies emphasize the need to harmonize the perspectives, knowledge, and strategies of the indigenous and conventional health systems.

The specific characteristics and health beliefs of the peoples examined in the six case studies are explicated as follows. The Mapuche peoples of Chile evaluate and self-evaluate their health status in their daily communication. Moreover, the Mapuche view recognizes four stages in the world, with identity and opportunity for imbalance directly rooted in these stages. The Mayas, in turn, recognize certain dualities in the sex of their deities and in some important opposites such as hot and cold or high and low. These dualisms are also important to the Nahuatls of Guatemala and the Quechuas of Peru. Furthermore, exclusively in reference to childbirth, the Quechua people consider a series of characteristics linked with the moment of birth such as light, heat, and vertical positioning to be relevant. The Honduran Garífunas worship their ancestors. To avoid their punishments, the priest, the *Buyei*, leads the community in a series of rituals centered on food, dance, and symbolism. The importance of dreams is the notable characteristic of the Panamanian Ngöbe-Buglé. To avoid the evil that can emanate from dreams, the priest, the *Sukia*, uses every means at his disposal to vanquish the evil spirit, known as the *Nicorare*. These beliefs pose challenges to health care delivery in the geographic areas inhabited by these peoples.

In practice, the results of several studies, analyses, and discussions with representatives of indigenous peoples have revealed both the incongruity between the organization and delivery of health

[23] Case studies on indigenous medicine were done in Chile, El Salvador, Guatemala, Honduras, Panama, and Peru. The documents will be published in the Series "Health of the Indigenous Peoples."

care and the dynamic of multicultural populations. In these discussions several countries have acknowledged the need to develop alternative health care models based on more accurate and comprehensive knowledge of the beneficiary population's characteristics, cosmic view, and resources. Examples of such models include Colombia in the Department of Vaupés[24] and Nicaragua in the North Atlantic Autonomous Region[25].

Challenges

Progress in conceptual development has facilitated actions to benefit indigenous peoples at the regional, national, and local levels; however, the following challenges have yet to be resolved.

- The ethnic, cultural, and linguistic heterogeneity of the more than 400 indigenous peoples that comprise the population of the Americas hinders the adoption of a single strategy for gaining a better knowledge of indigenous peoples.

- Several countries have taken the position that they do not have indigenous peoples or that all their citizens have the same rights and duties and, as a result, the same opportunities for access to health care. They argue, therefore, that there is no need to target care to a specific ethnic group (OPS, 1998a).

- The tendency to consider indigenous knowledge unscientific prevails in academia. The knowledge, attitudes, and practices of indigenous peoples have not been sufficiently incorporated into health analyses, human resource training, or the identification of health care strategies for indigenous populations. Translating socio-cultural data into practical information that will help to improve the access of indigenous peoples to quality care is one of the main challenges in public health.

- In every country in the Region of the Americas there is a substantial number of publications that relate to the culture, cosmic vision, organization, and lifestyles of its indigenous peoples; however, to date, this knowledge has unfortunately been considered of little use in the health arena.

Although it can be stated that the essence of the indigenous cosmic vision has continued through time, historical processes of the distant and recent past have shaped the practice of indigenous medicine and therapies. Depending on the country, knowledge and practices of pre-Hispanic origin have been, in some cases, influenced by Hispanic and African popular medicine. This medicine is handed down through oral tradition, learned through observation, and transmitted through training, initiation, heredity, or revelation by supernatural beings. This latter form of transmission, whose

[24] In Colombia, the model employed in the Department of Vaupés takes into account the socio-cultural characteristics, medicine, practices, and resources of the Tucano, Wanano, Piratapuya, Bara, Tuyuca, Pisamira, Desano, Siriano, Carapana, Tatuyo, Macuna, Barasana, and Taiwano peoples who inhabit this area (Guevara G., J. 1998).

[25] In Nicaragua, government implementation of the autonomous model has led the Autonomous Regional Board of the Autonomous Region of the Atlantic North, through the Health Commission, to take up the challenge of designing a health care model that will meet the needs of the Miskito, Sumu-Mayangna, criollo, and mestizo populations (University of the Autonomous Regions of the Nicaraguan Caribbean Coast, 1996).

reasoning extends beyond the mere understanding of health and disease limited to the workings of the body, is governed by a mythic religious and ideological framework. Indigenous knowledge should be understood not as static or atavistic knowledge but as dynamic knowledge that is continuously updated and syncretized (OPS, 1999; Ministerio da Educação, Secretaria de Educação Distancia, 1999).

Harmonization of Concepts: Strategies and Process Indicators

Strategies	Process Indicators
▪ In addition to officially recognizing indigenous peoples, incorporation of indigenous perspectives, medicines, and therapies requires the socio-cultural, demographic, and epidemiological characterization of the indigenous population in its particular geographical settings—that is, at the national, regional, and local area, in keeping with the specific characteristics of each country. When analyzing health and setting priorities, given the need to situate the indigenous population within the framework of the decentralization process, the importance of incorporating the proportion of indigenous population, its distribution by age and sex, and its specific ethnicity must be underscored. The knowledge of the social organization, cosmic vision, lifestyles, epidemiological profile, and, in many cases, the native language of the people in question are also of importance.	▪ Maps pinpointing the location of indigenous peoples by political division in the countries. ▪ Demographic data that include the number of indigenous people, in addition to the indigenous populations' distribution by age and sex. ▪ Data on the prevalence and incidence of the diseases in the particular population. ▪ Characterization of indigenous peoples in terms of their health and living conditions, social organization, and belief and values system, which all influence their knowledge, attitudes, and practices with respect to the health-disease process. This includes taking into account the different strategies of treatment, rehabilitation, disease prevention and health promotion from the indigenous perspective.
In expanding conceptual frameworks and conventional instruments and methods, it is necessary to restore to research its essential role as a constant critic of habitual practices, confronting these practices with concrete results achieved in practice in the health care of excluded populations, in this case indigenous peoples. In the specific case of indigenous peoples, ethical issues are relevant. The criteria for proceeding with research should be established in consensus with local indigenous organizations.	▪ The presence of multidisciplinary research teams made up of investigators and indigenous representatives, leaders, and healers. ▪ Studies that foster an understanding of the dynamic of social participation, health determinants, risk factors, and belief and value systems that influence the maintenance and restoration of health, attitudes, knowledge, and practices in terms of user preferences in conventional care, diseases, causes, and specific treatments. ▪ Instruments and methodologies that help to

	incorporate indigenous perspectives into qualitative and quantitative research. ▪ Instruments and methodologies that support the incorporation of indigenous perspectives, medicines, and therapies into primary health care. ▪ Instruments and methodologies that support research on the efficacy and safety of the practices and procedures of indigenous health systems.

5.3 Harmonization of Practices

Harmonization of practices is a process that promotes the formulation and implementation of models of care that give priority to the social and cultural characteristics of the beneficiary population (in this case, indigenous peoples), community resources, and the specific epidemiological profiles. This requires the training and development of human resources—indigenous and non indigenous—capable of respecting, understanding and responding to the different social and cultural contexts of the beneficiary population in order to deliver comprehensive health services to individuals and the community alike.

Progress

In 1999, with the support of the PAHO/WHO Representative Offices in Bolivia, Colombia, Ecuador, Honduras, Chile, and Nicaragua, a search was conducted for institutions that offered human resources training programs or courses emphasizing the socio-cultural knowledge of the beneficiary population. Table 9 outlines the information obtained. The general conclusions were that the curriculum contents of the academic centers and projects contacted did not include, on a permanent and consistent basis, sufficient knowledge about the socio-cultural context of the population that is served by the human resources who attend these institutions.

Table 9: Information on Training Programs that Include Sociocultural Information

Country	Academic Institution	Information Obtained
Ecuador	▪ Simón Bolivar Andean University ▪ School of Education and Andean Culture of the Bolívar University ▪ Andean Center for Popular Action (CAAP) ▪ University San Francisco of Quito, Medical School ▪ Central University of Ecuador, Medical School ▪ Pontifical Catholic University of Ecuador, Medical School	▪ Sporadic seminars on traditional medicine; ▪ Headquarters for events on indigenous issues ▪ Workshop for incorporating health into the education of indigenous teachers at schools for intercultural bilingual education; Herbarium ▪ Experience in training indigenous health promoters. Analysis of the health conditions of the indigenous rural population of the Sierra. ▪ Instructional materials ▪ Courses on health and integrated community development and on medical anthropology ▪ Headquarters of the UNI projects; Participation of medical students in medical care at three marginal urban dispensaries; Community health. ▪ Medical anthropology ▪ Community health ▪ Student practicums in the community
Colombia	▪ University of Antioquía, School of Nursing, Extension and Graduate Department	▪ Master's degree in public health. Experience in research since 1984. Multidisciplinary team of investigators. Areas of emphasis: indigenous maternal and child health, health education, and training of human resources, health professionals and health promoters. Gender and ethnic approach.
Nicaragua	▪ University of the Autonomous Regions of the Nicaraguan Caribbean Coast ▪ Center for Health Research and Studies	▪ Master's degree in intercultural public health; ▪ Majority of students indigenous. Interest in training human resources in cultural diversity ▪ Traditional medicine institute

	▪ BIKU University ▪ Christian Medical Action	▪ Interest in training health personnel in cultural diversity; Research that supports the intercultural approach ▪ Interest in training human resources in cultural diversity ▪ Programs for training human resources in cultural diversity
Bolivia	▪ Center for the Development of Social Management ▪ Bolivian Navy ▪ Bolivian-Japanese Technical School of Health	▪ Interest in training human resources in cultural diversity ▪ Interest in training human resources in cultural diversity ▪ Educational program for nursing auxiliaries based on the agricultural calendar. Indigenous students for the most part
Chile	▪ Mapuche Health Services ▪ Southern Health Association of the 9th Region of Chile ▪ Programa de Salud Mapuche (PROMAP) ▪ Universidad de la Frontera ▪ Hospital Makewe-Pelale, Temuco	▪ Experiences on health services delivery with community health workers and patient advocates that occasionally lead cultural sensitization workshops for health workers. Support in the Pediatrics course at the University of the Border. ▪ Amuldugum program with intercultural health facilitators trained to work in hospital and clinical settings. ▪ Lead workshops on sociocultural environmental issues affecting community health and health care delivery. ▪ Courses that include information on the socio-cultural aspects of the Mapuche population. ▪ 40 hour course on Mapuche Health and Culture that is offered several times a year for health professionals from around the country.

In the reports on the III Evaluation of the Goal of Health for All by the Year 2000, several countries (Bolivia, Ecuador, Honduras, Nicaragua, Panama, Paraguay, Peru, and Venezuela) cited geographical and cultural barriers as the main obstacles to access[26] and utilization[27] of the health

[26] The available definition of *access* refers to geographical access, stating that urban populations are considered to have access to public health services when the closest center is 30 minutes away and rural populations when the closest center is 1 hour away, using the transportation used most frequently by the community. However, we believe that this definition needs to include the problems related to the cultural and economic barriers that determine real access by the population to the health services.

services. These barriers are exacerbated by the lack of knowledge, about the sociocultural context of the population served, amongst the human resources involved in the health care of indigenous peoples.

The interest in knowing why potential users do not go to the health services accessible to their communities has led to qualitative studies in several countries.[28] The problems that users identify in health care can be grouped as follows: inconvenient hours of operation and lack of care, lack of drugs and supplies, poor referral and back-referral, lack of professional and support staff, very limited services outside the facility, mistreatment of patients, lack of infrastructure and equipment, lack of direct participation by the community in health efforts, and lack of participation by local agents in the health of the population. Although we can cite experiences, the practical impact of this information on conventional health systems and services needs to be explored. For example, the Indigenous Health Care Subsystem in Brazil has multidisciplinary teams who receive introductory training that includes anthropological content, analysis of the epidemiological profile of the region, and training that renders them competent to participate in the training of indigenous health workers.

Moreover, in the structure of the Indigenous Health Care Subsystem of Brazil, the Local and District Indigenous Health Councils play an important role. The basic function of the District Councils is to approve the District Health Plan and to monitor and evaluate its execution along with resource use. The Local Councils are made up of representatives from indigenous communities, including traditional leaders, chiefs, and traditional healers (Pajés), who are chosen by the members of their own communities and whose main function is to identify the specific health needs of their peoples (FUNASA, 2001).

In addition, governmental and nongovernmental organizations have activities that promote good relations between indigenous and conventional health systems. Examples include the hospitals governed by the Indigenist Institute of Mexico and the Jambi-Huasi Health Center of Otavalo, Ecuador.[29]

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[27] In this document, utilization is understood to be the degree that an easily accessible service with sufficient staffing and equipment is used.

[28] Among the studies that seek to explore quality from the user's perspective we can cite: Freyermuth G. *Carpeta Informativa: Muerte Materna en el Municipio de San Pedro de Chenalho.*[Report: Maternal Death in the Municipality of San Pedro de Chenalho] San Cristóbal de las Casas, Mexico, 1996; Frisancho A, Masala G, Motta F, Johnson J, Garrido E. *Salud Comunitaria en el Ande Peruano: Reflexiones sobre una experiencia de cooperación con médicos y enfermeras en servicio rural,* [Community Health in the Peruvian Andes: Reflections on Cooperation with Physicians and Nurses in Rural Service] 1993; Sola, J. *Condiciones de Salud de la Población Campesino-Indigena de la Sierra*. [Health Conditions of the Indigenous Campesino Population of the Sierra] Centro Andino de Acción Popular (CAAP), Quito, Ecuador, 1995).

[29] In Ecuador, the Federation of Indigenous Peoples and Campesinos of Imbabura (FICI) coordinates and administers the activities of Jambi Huasi (Quichuan for house of health). This center provides medical care in Quichua (the native language) and Spanish, provides both conventional and indigenous medical care, and has indigenous professionals trained in conventional medicine (physicians, nurses, dentists) as well as indigenous healers (yachacs, midwives, bonesetters, traditional diagnosticians).

Challenges

There is growing interest in the countries of the Region in applying the knowledge accumulated by indigenous peoples to health care, and in developing theory and practice in this area. The following challenges to transforming the results of research and experiences into useful activities in academia and health systems and services have been identified.

- Human resources development is one of the priority areas of the national health plans and the sectoral reform processes and is a basic strategy for health systems and services development. However, direct participation by the community, universities, and schools of health sciences in the organization and delivery of health services to the population is generally still a new phenomenon.

- The current educational profile, the knowledge, skills, competencies, and attitudes required to do the work demanded by the occupational profile of health workers does not correspond to the functions that the health workers are called on to perform. While the educational profile is oriented chiefly to performing a practical task within a service delivery unit, the responsibilities, functions, and actions of this staff, particularly physicians when facing the realities of practice, must be geared towards the following: managing and administering the health services, promoting community development and participation, training human resources in the health facility and the community, and conducting operations research on the local health situation within a multicultural context.

- Medicine grounded in biomedical principles is generally curative and restorative in nature. The restorative nature of medical practice also involves the mass utilization of drugs. With ample availability of pharmacies, the freedom of health workers to prescribe drugs in the majority of Latin American and Caribbean countries and, especially, the need to respond immediately to the demands and complaints of patients, have led to the over-prescription of drugs and the medicalization of health care. Given the urgent need to cure and resolve cases, the preventive, rehabilitative, and health promotion activities carried out by the medical services are limited and inadequate (Estrella, 1984)

- The mechanisms for technical and administrative supervision as well as for monitoring and evaluating the performance of these human resources are insufficient. The result is an inadequate personnel administrative structure that offers poor or nonexistent incentives, fails to strengthen workers' commitment and technical capacity, and ends up exacerbating the inequitable distribution and low productivity of health workers.

- Ignorance and under-appreciation of the uses and response capacity of indigenous medicines and therapies by the public sector, the presence of gaps in the law or legal instruments and codes that rule out or proscribe such practices, and the lack of understanding and respect for this medicine as an integral part of the indigenous culture and cosmic vision have cast aside a community resource that is important to indigenous and non-indigenous populations alike when formulating models of care.

- Harmful practices such as the use of contaminated substances and/or instruments in open wounds, improper procedures, side effects from drugs, iatrogenesis, etc. are points that are often

emphasized when describing indigenous medicines and therapies when, in fact, these aspects should be considered in both indigenous and conventional health systems.

Harmonization of Practices: Strategies and Process Indicators	
Strategies	**Process Indicators**
▪ Training and developing technically competent human resources that can provide timely, effective, and culturally appropriate health care is important when developing and implementing models based on legal frameworks as well as when developing duly financed policies for improving access and the quality[30] of care offered by governments to the population of the Americas, especially indigenous peoples. Thus, the following is proposed: to facilitate the training and professionalization of indigenous people and to review and to adapt programs for training and developing human health resources in order to strengthen managerial, political, administrative, and technical capacities. This requires the strengthening of the coordination among Ministries of Health (administrative, managerial and technical entities) with academic institutions and the incorporation of knowledge that facilitates: ▪ an understanding of the socio-cultural context of indigenous peoples to permit adequate, effective interactions between professionals and people of diverse cultures, educational, and professional levels and lifestyles; ▪ an understanding of the role played by cultural, social, and behavioral factors in the disease process, prevention, the promotion of healthy lifestyles, and the organization and delivery of health services; ▪ the development and adaptation of policies, plans, programs, and interventions, taking into account the socio-cultural differences of the	▪ Number of indigenous people in training and human resources development programs. ▪ Number of indigenous people with positions in the health systems and services structure. ▪ Programs for the training and development of human health resources that include contents related to: ▪ The historical processes of the Americas and the health and living conditions of the indigenous peoples of the Region. ▪ Access and quality of care from the perspective of indigenous users of the conventional health system. ▪ An intercultural approach to the health sector reform processes and an analysis of their impact on health care for indigenous peoples. ▪ Ethnicity and culture as an analytical variable in setting priorities. ▪ Ethnicity and culture as an analytical variable in adapting health programs that target multicultural populations. ▪ The indigenous cosmic vision and cultural beliefs. ▪ Components of the indigenous health systems

[30] Quality requires that the users of the services receive timely, effective, and safe care (technical quality) under adequate physical and ethical conditions (perceived quality) (OPS, 1997).

population..	such as therapeutic resources and healers. ▪ Challenges in implementing the integrated approach to health. ▪ Reflections on biodiversity, intellectual property, practices, and traditional medicine. ▪ Ethnoepidemiology. ▪ Research with indigenous peoples.
▪ Reviewing the standards for quality and the response capacity of the conventional health system will help to identify its strengths and weaknesses. Therefore, it is important to have strategies that facilitate consideration of the economic, social, and cultural barriers that impede access by the indigenous population to health care, as well as improvements in health workers' performance, changes in the hours of operation, arrangement of the physical space, and improvements in the technical procedures employed by the public health services.	▪ Health care incorporating strategies that facilitate communication between health workers and patients and health workers and the community, within the framework of the codes and languages of the indigenous peoples. ▪ Health care incorporating strategies that bring health care to the community. For example, extramural activities and periodic visits by mobile health workers. ▪ Training for health workers and community health care strategies that consider the lifestyles, knowledge, and belief and value systems of indigenous peoples. Examples include adapting the services' hours of operation, arranging the physical space, setting up herbariums, including medicinal plants in the list of basic drugs, and multidirectional shared training of health care providers from the conventional and indigenous systems.

Indigenous problems are complex. Academic and institutional treatment of indigenous problems occurs at the intersection of issues such as human rights, democracy, development, the environment, and an understanding of the culture, identity, and cosmic vision of these peoples. Effective incorporation of the holistic perspective of indigenous peoples into health systems, with the object of improving the health of indigenous peoples by making use of their ancestral experience acquired over millennia, requires political commitment and responsibility on the part of countries and international organizations in conjunction with the promotion of multisectoral, multidisciplinary efforts which ensure indigenous peoples enjoy full participation as social actors.

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7. Annex

Examples of National Legal Frameworks that Promote Health Care for Indigenous Peoples of the Americas

Bolivia: Law 1551 on Popular Participation, created by Supreme Decree 24237 establishes, among its other provisions, that the resources for the administration of the health services' infrastructure will be assigned to the municipal governments and that neighborhood boards, campesino communities, and indigenous peoples will participate in decisions with respect to resource allocation, use, and monitoring. (Suggestion: Put the year this law was passed)

Brazil: through the National Health Foundation (FUNASA), in 1999 the Ministry of Health assumed responsibility for all disease prevention activities and medical care for the indigenous population. Its principles included respect for the socio-cultural characteristics and traditional health systems of indigenous peoples.

Colombia: Article 181 of Law 100, referring to types of health promoting agencies, indicates that the National Health Authority can authorize NGOs and community welfare organizations established for this purpose, especially community-oriented health enterprises and indigenous community organizations, to act as health promoting agencies

Ecuador: As the Minister of Health indicates in a communication sent to PAHO, the creation of the National Indigenous Health Bureau(DNSPI) through Articles 44 and 84 of the Constitution in September of 1999, is one of the first acts that harrmonizes the structures and functions of the Ministry of Public Health with the constitutional precepts that guarantee the development and recognition of traditional medicine.

El Salvador: The effort to make the indigenous populations' health problems visible has made possible the participation of indigenous representatives in the development of plans and strategies to provide health care to indigenous peoples.

Guatemala: The national government put together Health Policies 2000-2004, a strategy that incorporates, orients, and supports the health sector reform and commitments made in the peace agreements. These policies give explicit priority to the health of the Maya, Garífuna, and Xinca peoples, with emphasis on indigenous women.

Guyana: Community-based rehabilitation programs are working with children in rural communities and in the Rupununi region as part of an intersectoral effort.

Honduras: In 1994 the Ministry of Health created the Department for Ethnic Affairs and is implementing a plan based on the commitments assumed by the Honduran government with its ratification of ILO Convention 169, its ratification of various Resolutions as a Member State of PAHO, and its ratification of the Conservation of National Resources Law.

Panama: The authorities have supported the development of indigenous peoples by making indigenous issues one of the 10 priorities on the Social Agenda for the period 1999-2004. In 1999, in order to ensure implementation of the activities included in the Social Agenda, the Ministry of Health created the Health of Indigenous Peoples Section in the Office of the Director of Health Promotion and put together the Initiative for Development of the Indigenous Populations of Panama, whose objective is: "To help improve the living conditions and quality of life of the Ngobe-Buglé, Emberá-Wounaan, Kuna, Naso, and Bri-Bri peoples and their environment, by establishing policies and strategies aimed at the promotion, prevention, care, and rehabilitation of health through an intercultural approach."

Peru: Expansion of coverage to areas inhabited by indigenous populations has taken place through the Health Service for Rural and Marginal Urban Areas (SERUMS). Through this service, the universities, professional schools, and other institutions as well as the National School of Public Health's research and distance learning programs have assumed special importance. In 1990, Legislative Decree #584 and Supreme Decree #002-92 SA created the National Institute of Traditional Medicine (INMETRA) within the Peruvian Ministry of Health.

Venezuela: Since 1996 CENASAI, the Civil Society for Endemic Disease Control and Health Care for the Indigenous Population has been implementing the Health Care Project for the Indigenous Population (ATSAI), engaging in activities designed to promote individual and collective health in the indigenous communities in the southern state of Bolivar, with the general objective of helping "to improve the quality of life, intervening basically in the area of health."