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ROLES OF LOCAL ORGANIZATIONS AND INDIGENOUS COMMUNITIES AS AGENTS FOR THE MOBILIZATION OF BASIC COMMUNITY SERVICES

Dr. Pilar Mazzetti Soler
Minister of Health
Peru

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ROLE OF LOCAL ORGANIZATIONS AND MOBILIZATION OF INDIGENOUS COMMUNITIES FOR DELIVERY OF BASIC COMMUNITY SERVICES.

Introduction:

1. Analysis of the health status of indigenous peoples entails the need to understand the complexity of the health-disease situation in this population from various perspectives. In the majority of cases, this analysis goes beyond the biomedical field to position itself within a broader context, which involves primarily the social, economic, and political sciences.

2. Furthermore, the heterogeneous ethnic and cultural composition of indigenous peoples makes it difficult, if not impossible, to apply single programs or universal models for health care. It is precisely this diversity, accentuated with respect to such a culturally sensitive aspect of life as health, that makes it necessary to consider every indigenous people individually and to stress the development of research and care strategies from a perspective that is not only local but culturally specific in nature.

3. Cultural diversity in the Americas is based on the presence of approximately 45 million indigenous persons belonging to more than 400 different indigenous peoples (OPS, 2002). Despite the progress made in the Region in reducing the burden of disease and death, the disparity in health indicators in indigenous peoples and other vulnerable populations continues to be alarming. Several studies reveal that illiteracy, unemployment, lack of land and territory, high morbidity and mortality from avoidable causes, and limited access and use of basic services of health, education, housing, and other sectors are problems that affect the majority of indigenous communities and influence their quality of life and health status.

4. It should be recognized that one of the first responses to this situation came from the countries of the Region, acting through the Directing Council of PAHO in 1993, and then in 1997, with the development and promotion of the Health of the Indigenous Peoples Initiative. This initiative emphasized the ongoing participation of indigenous peoples in the solution of their own problems and recognition and respect for their ancestral wisdom.

5. The Health of the Indigenous Peoples Initiative has been characterized by its capacity to pull together the efforts of the programs and proposals of the countries themselves. It has been effective not in advocating for the well-being of indigenous peoples in regional, national, and local forums, but also in forging strategic partnerships and networks that have promoted processes to improve the health status of these peoples. One of its significant results has been the formulation of policies, strategies, plans, projects, and institutional and community programs for human resources development.

6. Conceptual and methodological development of the intercultural approach to health based on the concrete experiences of the countries of the Americas has been an important reference point for bringing health care to indigenous communities and for improving the effectiveness of health service delivery, taking indigenous resources, perspectives, practices, therapies, and medicines into account. The generation and dissemination of technical, scientific, and public information has not only made it possible to share the cumulative experience of the countries but also to affect the production and use of knowledge about the health of indigenous peoples.

Background:

7. Each indigenous people has a distinct cultural profile as a result of its particular history. The indigenous population cannot be approached in a homogeneous manner, since different peoples have different conditions and their own organizational and cultural systems. They differ in how they have been impacted by development; they live in different ecosystems with different levels of degradation or conservation; they have developed different strategies for survival, resistance, or adaptation; they have had different experiences with capitalist development; and they have reacted in different ways to acculturation processes.

8. The specific cultures of indigenous peoples are reflected in their ways of understanding health and disease and life and death, which differ from the understanding of nonindigenous society.

9. Since the morbidity profile of the indigenous population is different from that of other social groups, proposals for differentiated care and "differential actions" are increasingly valid. We can cite several experiences in the Region where attempts have been made to provide such differentiated care, among them that of Peru in 1998, which involved the development of a new way of extending health services to communities that are hard to reach for geographical, cultural, economic, and political reasons, using itinerant teams. This new type of intervention employed a multidisciplinary team of made up of professionals from the health and social sciences. Each team had a physician, nurse, midwife, psychologist, biologist, and an anthropologist or sociologist, depending on the epidemiological profile of each area. The work of these itinerant health teams, called ELITES, continues. Over the years, their coverage has expanded to care of the most vulnerable groups in these populations, such as children under 5, pregnant women, the elderly, and others.

10. This represents some measure of greater attention by the health services to needier populations, such as indigenous communities, as well as adaptation of the supply of health services on the basis of ethnic, cultural, religious, and social characteristics.

Current Situation:

11. According to PAHO/WHO[1], indigenous populations are very young. The Census of Indigenous Communities in the Peruvian Amazon Region reports that 50% of the population in this area was between 0 and 14 years of age, versus 30% in metropolitan Lima (OPS, 2000). Of all age groups, the one most affected by disease is the infant population. Given the level of underreporting of vital and morbidity statistics, we can presume that the actual morbidity and mortality figures are higher than the ones indicated.

12. On average, the infant mortality rate in the indigenous communities of Panama is 84 per 1,000 live births compared with the national average of 17.2; 32 per 10,000 indigenous children under the age of 5 die from diarrhea compared with the national average of 6.4 per 10,000. That is, the rate is more than five times the national average in indigenous communities (Ministerio de Salud, 2000). There is a similar pattern for maternal mortality in Honduran departments with larger proportions of indigenous or Afro-descendent populations. The maternal mortality rate is alarming in the departments of Atlántida (159 per 100,000 live births), Lempira (190 per 100,000 live births), Columbus (200 per 100,000 live births), Copán (203 per 100,000 live births), La Paz (229 per 100,000 live births), and Intibucá (255 per 100,000 live births). It is much higher than the national average of 147 per 100,000 live births (UNDP HDR, 1999, Ministry of Health, 1997, Soriano, I., 1999).

13. Poor basic sanitation, such as the lack of clean water and inadequate excreta disposal systems, are among the leading causes of morbidity and mortality, particularly among children. In El Salvador, for example, 95% of surface water sources are contaminated, leading to an average of 4.1 diarrhea episodes per year in children under 5. Some 40% of indigenous children in El Salvador are malnourished, as compared with the national average of 20%. Malnutrition is associated, *inter alia*, with parasite infections stemming from poor environmental conditions (Report of the Project on Conditions of Environmental Sanitation in Indigenous Communities, 2004). These bad conditions, sometimes associated with high levels of overcrowding, contribute to the incidence of infectious diseases such as trachoma and tuberculosis in indigenous communities.

14. In Mexico, mortality rates from pulmonary tuberculosis in the indigenous population are twice as high as in the general population (Comisión de Desarrollo de los Pueblos Indígenas de México, 2004). In the Municipio of Chenalho, Alto Chiapas, Mexico, an area with a high proportion of indigenous population, data from 1999 show that measles and malaria are among the 10 leading causes of death. In Suriname, as in French Guiana, 70% of malaria cases originate in the Maroní river basin, an area inhabited by peoples of indigenous origin and African descent (Aldigheri, 2000).

[1] Dr. Rocío Rojas. Health of the Indigenous Peoples Initiative 2005–2015. PAHO/WHO

15. The paradox is that despite the traumas and problems, these peoples have developed survival mechanisms and a strength that can only be explained by the harshness of their situation and their unbreakable will to carry on born of the same adversity. Linguistic, organizational, and leadership potential and crossing beyond the current political borders, which often obscure the ancestral experience of peoples are but some of the strategies being used to enable these peoples to endure. In fact, a supranational map of the Americas would show us the living presence of multinational indigenous peoples such as the Maya of Mexico, Guatemala, and Belize; the Quechua of Colombia, Ecuador, Peru, Bolivia, and Argentina; and the Guaraní of Bolivia, Paraguay, Argentina, and Brazil. All this leads us to conclude that the current borders are relative and that cooperation among the countries is essential to addressing the health of these peoples.

16. With regard to location, today's indigenous populations are generally scattered. In some cases they are mobile; for the most part, they are located in marginal areas in cities, rural zones, and border and remote areas. Health coverage, already generally low in rural areas, reaches its most critical levels in indigenous areas. If to this we add the cultural barriers between health service providers and the indigenous population, the problem of real access to quality health care is critical. For example, in the Amazon region of Ecuador, health brigades visit the indigenous communities only once every 3 months (OPS, 1998). Though of inestimable value, community knowledge and practices, together with indigenous healers and community resources can only meet part of the health needs, given such a complex epidemiological profile.

17. In Alto Río Negro in Brazil, for example, there are two hospitals qualified to diagnose and treat cases of tuberculosis. The region has an area of approximately 8 million ha, and the distance from the hospitals to indigenous communities ranges from a few minutes to several days of travel on foot through the forest or by canoe, depending on the weather. The problems of physical access, added to indirect costs (cost of transportation, food, food for the family that stays in the village, gasoline, etc.) can lengthen the time between the onset of the first symptoms and seeking health care (Buchillet, 2000).

18. Given this reality, it is necessary to identify strategies that will make it possible for formal health care to reach this population. This means using innovative approaches that consider cultural differences such as language and communication, values and beliefs, social organization, ways of life, organization of time, and the community's own therapeutic resources. As a rule, in many indigenous communities, the indigenous language is the one used for daily communication among all age groups, including the children. The tendency to speak only the indigenous language is evident among adult women and older adults who are, in many cases, those responsible for caring for the children.

19. The importance of this can be seen when we consider that there are signs, symptoms, and diseases that only have names in the indigenous language or colloquial

Spanish; knowing the right word can simplify diagnosis and help identify the symptom that is understood as the expression of the disease.

20. The quality of the relationship between the health provider and the person seeking health care is critical. Usually, health workers limit themselves to giving the patient some quick explanations about their disease or its mode of transmission, its progression, and the need to follow the prescribed treatment, without taking the trouble to find out whether the information was really understood. Studies show that, when given in the country's dominant language, explanations by health workers to indigenous or culturally different populations are frequently not understood by them (Jackson, 1996). Sometimes the patient is accompanied by a bilingual relative who acts as an interpreter, but if the health workers are not conversant with the indigenous language, they have no control over the information transmitted.

21. Effective training of health workers is essential and involves an interest in learning the indigenous languages and communication codes of the communities. Usually, attitudes indicating a lack of understanding of the indigenous peoples' problems come from an almost total ignorance of what these peoples are and what they know. Discrimination and the abuse of indigenous patients are not rare occurrences.

22. Personnel involved in providing health care to indigenous peoples should know the number of people and their distribution by ethnicity, age group, and sex in a given community or region. Technical know-how is also indispensable. This includes knowing, given the epidemiological profile of the population, the clinical course of disease, methods and techniques for clinical and microscopic diagnosis, basic knowledge of entomology, and, especially, knowledge about the particular population and the determinants of its health and living conditions. Of course, adequate provision of appropriate supplies for the epidemiological profile of the community's population is important, as is the strengthening of managerial capacity to handle emergencies and promote health as part of the community's social and economic development.

23. This sampling of data has shown the magnitude of the problems that affect the indigenous peoples of the Americas. It is important to underscore the importance of having more quantitative data and research that can draw a clearer picture. Nevertheless, it is qualitative research that can make it possible to know the context for the numbers and thus to understand the health-disease connection from the perspective of the indigenous world view.

Conclusions:

24. Last year was the final year of the Decade of the World's Indigenous People. The processes for attaining the Millennium Development Goals are continuing. What progress has been made in the world? What progress has been made in our Region? And in each of

our countries? Can we detail the progress made in health care for indigenous peoples, and within those populations men, women, young people, the elderly, and especially children?. Based on what was stated earlier, here are some responses:

- Indigenous peoples currently constitute a broad and **heterogeneous** group within an alien society. However, they still have characteristics that distinguish them from the national society in which they have been incorporated.

- Indigenous populations are particularly **vulnerable** groups**,** with precarious living conditions. They are especially marginalized with respect to the most basic services, with very few possibilities of being considered in development models and facing the constant dilemma of whether to join the globalized world or remain outside of the process and maintain their identity.

- Each indigenous people has a **distinct cultural profile** as a result of its particular history. Indigenous population cannot be treated as homogenous, since different peoples have different conditions and their own organizational and cultural system. They have been affected differently by development processes, live in a variety ecological environments with different levels of degradation or conservation, and they have developed different strategies for survival, resistance, or adaptation. They have experienced different processes for linkage with capitalist development, and they have reacted to acculturation processes in different ways.

- Indigenous peoples have different ways of **conceiving health and disease,** life and death, which differ from the understandings of the nonindigenous society.

- There are serious limitations in the availability of information on indigenous peoples. They are **underrepresented** in census information, and since ***ethnicity*** is not considered in the registries, the profiles for health, education, employment, and housing, etc. are all unknown.

- Nonindigenous health workers in health facilities that treat indigenous populations in most cases do not receive vocational training with an intercultural approach. The Ministries of Health have not corrected these deficiencies, and as a result nonindigenous workers tend to discriminate, **undervaluing the health practices** and traditional medicine of indigenous peoples.

- Every plan for improving the health of a population should be based on an adequate diagnosis of the situation—the main objective of the processes for **Health Situation Analysis** (ASIS) developed in Peru—which makes it possible to keep information on health status up-to-date, to identify the factors that determine and affect it, and to identify the resources of the health systems themselves and the degree of access

to state health services, thus identifying gaps in equity in order to draw up policies and plans of action that help improve health conditions.

- The traditional biomedical approach is not enough for an adequate diagnosis of the situation of indigenous peoples of the Amazon. It is also necessary to incorporate perspective of the social sciences, as well as economic and political approaches, making possible a comprehensive vision of the situation.

25. From the previous remarks, the following areas can be considered key health problems in the indigenous Amazon region:

- The public health system is not responsive to indigenous cultures and needs; instead it excludes them from the health development process and subordinates indigenous medicine to western medicine.

- Public health services for indigenous peoples in the Amazon region are characterized by low coverage of health care needs, are rather accessible to the population, have few resources and limited management capacities, and are not considered a national priority.

- Decentralization of the health sector in the indigenous Amazon region is just beginning, extremely weak, inequitable, and suffers from limited participation by indigenous organizations.

- Human resources for public health in the Amazon region are insufficient, lack training suited to the cultural reality, and are biased toward institutional care.

- There is high morbidity and mortality from emerging diseases among indigenous peoples, especially mothers and children, as well as low coverage by disease control programs, weak epidemiological surveillance, and a failure to control the impact of environmental and migratory factors.

Recommendations:

26. Much remains to be done and the moral debt that society owes to indigenous peoples is even greater. These are some proposals that we offer in the search for ways to reverse this situation:

a) We must achieve a coherent position in our policies, that will enable us to establish an adequate relationship between the ethical and regulatory framework, the programming framework, and the instrumental or operational framework. It is clear that health policies alone are not sufficient for obtaining the desired impact on the health and social situation of our indigenous populations. In this perspective we

propose that the linchpin of our efforts should be the focus on human rights in health as a way to view reality and act on it. Within this framework, the elements of inclusion, of citizen participation, of giving priority to local areas and vulnerable and excluded groups, and of a shared culture of transparency and commitment should serve as the basis for the building of citizenship in health as a precondition for the viability and sustainability of our policies, plans, and programs.

b) Public policies should be healthy, that is to say reflecting, in an explicit way, a new social pact that should be built on understanding of a political definition of health, that strengthens intersectoral action and makes it possible to affect the key determinants of health in the conviction that by transforming them we will succeed in creating conditions for human and social development. This is indispensable for achieving healthy people and societies that overcome the deficits in equity and governance that are key characteristics of the countries of our Region.

c) We must promote the Program for Health of Indigenous Peoples that PAHO/WHO has developed, making sure that through this program, technical assistance is provided to the countries for their efforts to incorporate indigenous peoples in the management of basic services for their own communities.

d) We must urge the international community to meet its commitments to reduce poverty and promote the social development of indigenous communities. This includes the need for the developed countries to meet their commitment to allocate at least 0.7% of the GDP as official development assistance.

27. Finally, it is important to underscore that improving the health of these peoples will involve application of the national and international legal framework for these actions and the elements of indigenous participation and community action. The relevant international agreements are Convention 169 of the ILO (1989), the UN Declaration of the International Decade of the World's Indigenous Peoples (1994), Resolution CD37.R5 (1993) and Resolution CD40R6 (1997) of PAHO/WHO. However, it is above all the legal advances at the national level that have facilitated a respectful approach to the indigenous reality and indigenous health systems. This has resulted in the possibility of harmonizing the national and indigenous health systems. In this context, it is important to recognize that in the formulation, ratification, and implementation of these agreements, declarations, and conventions, leadership and the continuing struggle of indigenous peoples for their rights have been decisive factors in the international and national areas.

28. Disease can only be conquered when individuals and the community know their rights and take control of their well-being into their own hands. This assertion is not new. In 1978, more than 25 years ago, in the Declaration of Alma-Ata, the International Conference on Primary Health Care said that primary care requires and promotes self-development and community and individual participation at all levels, including the

planning, organization, development, and control of health care. For those of us who have the responsibility for serving the needs of indigenous peoples, it is therefore essential to consider the perspectives on life and culture of the communities that we serve.

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