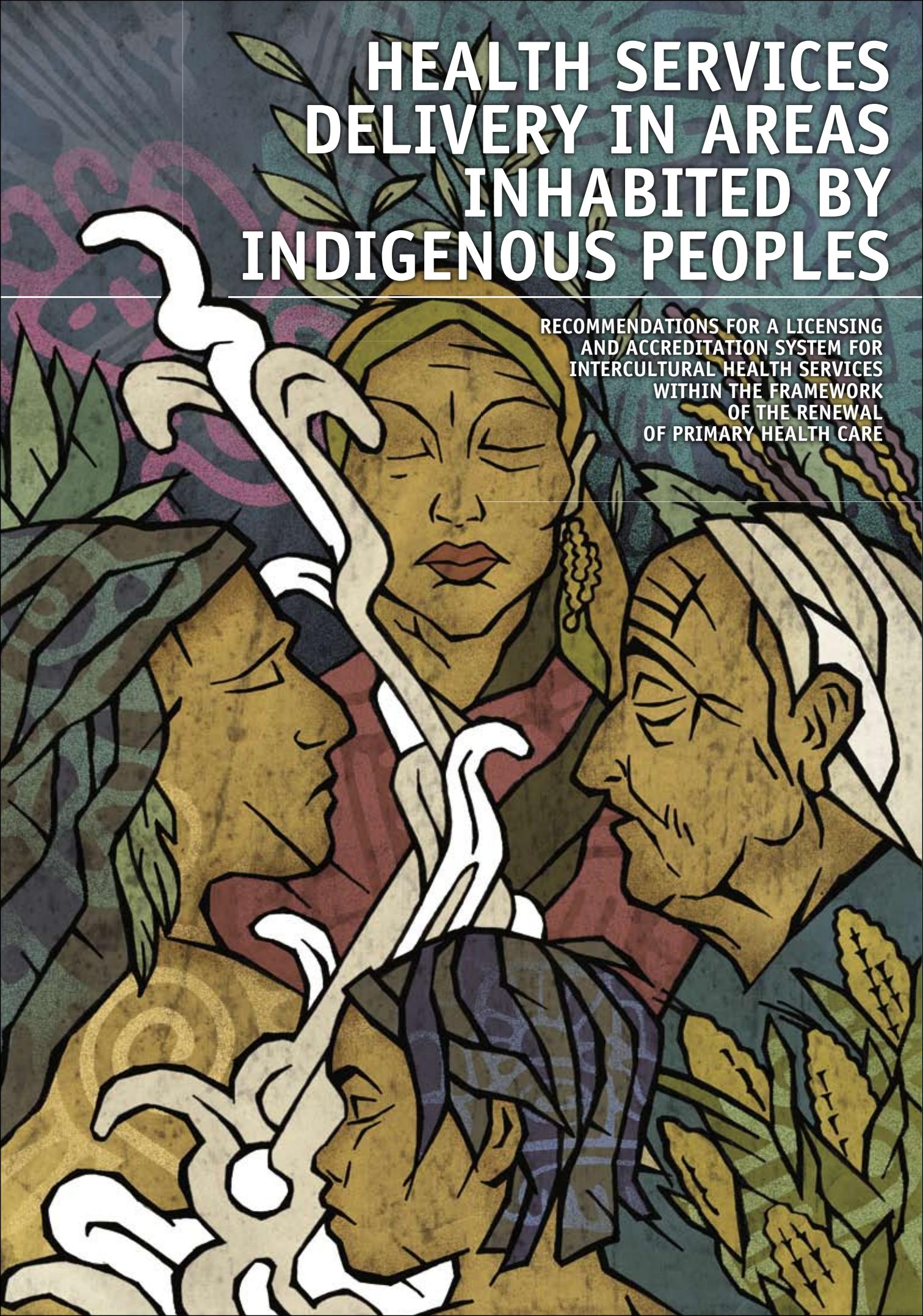


HEALTH SERVICES DELIVERY IN AREAS INHABITED BY INDIGENOUS PEOPLES

RECOMMENDATIONS FOR A LICENSING
AND ACCREDITATION SYSTEM FOR
INTERCULTURAL HEALTH SERVICES
WITHIN THE FRAMEWORK
OF THE RENEWAL
OF PRIMARY HEALTH CARE



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CON- TENTS



01_ FOREWORD	07
02_ INTRODUCTION	09
03_ INDIGENOUS PEOPLES' HEALTH: PRIMARY HEALTH CARE AND INTERCULTURAL FOCUS	13
04_ VALUES AND PRINCIPLES IN RENEWED PRIMARY HEALTH CARE	21
05_ CONCEPTUAL APPROACHES: HEALTH, INTERCULTURAL FOCUS, QUALITY, ACCESS, LICENSING, ACCREDITATION, PRIMARY HEALTH CARE	27
06_ HEALTH SERVICES DELIVERY IN AREAS INHABITED BY INDIGENOUS PEOPLES: PRIMARY HEALTH CARE AND INTERCULTURAL FOCUS IN BOLIVIA, BRAZIL, CHILE, ECUADOR, MEXICO, PANAMA, VENEZUELA	37
07_ ELEMENTS WORTH CONSIDERING IN AN INTERCULTURAL LICENSING AND ACCREDITATION SYSTEM	55
08_ CONCLUSIONS	63
09_ RECOMMENDATIONS	65
10_ REFERENCES	69
11_ ANNEXES	71



FORE- WORD



The Americas are a heterogeneous universe not only from the economic, social and cultural perspectives but also due to the multicultural, multi-ethnic and multilingual facets of its population. This diversity is mainly linked to the presence of indigenous peoples that represent nearly 50 million persons who belong to more than 600 different peoples.

Though there are several countries where comprehensive health care systems based upon socio-cultural contexts are privileged at national level; there is a predominant vast array of segmented programmes with almost no presence of indigenous communities. At this level, marginalization linked to cultural reasons, ethnic origin or native language is prevalent. Sometimes access to adequate health care is a matter of proper information. Those most in need of health services often times lack worldly experience and ignore what services are available to them, particularly if there are language and cultural barriers.

In general, the differences in language, communication, values, beliefs, lifestyles and time conceptions, have not been duly taken into account in health care services. This has generated problems related to health staff performance, service hours, or physical positioning and technical procedures applied in public health services. Each one of these factors illustrates the lack of consistency between health services organization and delivery and the internal dynamics of multicultural populations.

Thus, in-keeping with the principles of primary health care, we are pleased to present a set of recommendations for the development of a licensing and accreditation system for intercultural health care services. We remain convinced that the incorporation of an intercultural focus in health care models appear as a positive strategy to improve equity in access to quality health care for all and particularly for indigenous populations living in the Region. The same approach should be applied to quality standards assessments of health services operating in areas inhabited by indigenous and multicultural populations.

The implementation of these recommendations and the readers' feedback shall contribute to enrich this proposal which is based on the conviction that health is a right that should be construed as the physical, psychological, social and spiritual state of well being which must be fully and equitably enjoyed by any individual, community or society.

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INTRO- DUC- TION



Between 45 and 50 million indigenous persons¹ belonging to over 600 unique peoples live today in the Americas. They represent almost 10% of the total population in Latin America and the Caribbean and 40% of the Region's rural population (Inter-American Development Bank 2003, PAHO 2004). Indigenous peoples' contribution to the vitality and diversity of the 24 countries they live in is quite significant. They are the guardians of most of the cultural heritage and biological diversity of the American continent. Notwithstanding their invaluable contributions, indigenous peoples² remain extremely vulnerable within their own countries, where their human rights and their social, political and economic equality have been either denied or seriously undermined.

Poverty and extreme poverty show higher rates of incidence among indigenous peoples than among non indigenous populations in the Americas. Poverty is further compounded by other factors such as significantly higher illiteracy rates, unemployment, lack or absence of social services, human rights violations, conflict-triggered displacements and environmental degradation.

Though indigenous populations represent a majority in several countries and geographical areas in the Region, 40% of them lack access to conventional health services and 80% depend on traditional healers as their main health services providers. This situation is exacerbated

by gender-based inequalities, particularly in the case of indigenous women who face countless difficulties in obtaining quality health care, especially regarding reproductive health services.

While it has been acknowledged that the quality in health services delivery in many developing countries leaves to be desired, the situation is even worse in areas inhabited by indigenous populations. Geographical barriers prevent indigenous peoples from gaining access to health care, among other reasons, due to the long distances between their homes and available health facilities, lack of transportation, non-existent or poorly maintained roads and seasonal inaccessibility. Even if, formally, health care for indigenous peoples is free of charge in certain countries, in practice, the real costs of i.a. transport and mobilization, lodging, expenses incurred by accompanying relatives or friends, adverse effects on the patient's dependants livelihoods and loss of earnings, they all represent as many threats to the patients' economic situation and their access to primary health care.

Cultural barriers pose the most complex challenge since there is little understanding of the social and cultural factors linked to the knowledge, attitudes and practices related to indigenous peoples' health. Western medicine and intervention bias could be offensive or inappropriate for traditional medicine practitioners. It is difficult to find

health staff members who can speak and understand indigenous languages and the lack of meaningful communication between health services providers and patients at all levels of health care undermines their access to quality care. Furthermore, indigenous individuals are often discriminated against by non indigenous staff. Fear and mistrust fuelled by the attitudes and behaviour of health care workers are yet additional barriers that deter indigenous peoples from seeking the health care they need. For example, traditional practices and beliefs regarding childbirth are often disregarded in institutional contexts.

Thus, the important need to define, from an intercultural perspective, *quality standards* for health services delivery that duly respect the habits, traditions, language, ancestral knowledge and lifestyles of indigenous peoples. These standards can and should be incorporated in the search for technical excellence in health care within the context of the achievement of the Millennium Development Goals and the renewal of Primary Health Care.

This was the driving force behind the *Workshop on Experiences Regarding Indigenous Peoples Health (Annex 1)*, sponsored by PAHO's Health Programme of the Indigenous Peoples of the Americas, which was organized in Quito, Ecuador, on November 7 – 9, 2005. Representatives from Bolivia, Brazil, Colombia, Ecuador, Guatemala, Mexico, Nicaragua, Panama and Venezuela attended the meeting,

amongst them, indigenous leaders, public health officials and PAHO consultants.

The workshop's main purpose was to identify different elements that should be considered in the development of a licensing and accreditation system which duly takes into account the guiding principles of primary health care and an intercultural approach to health.

The **specific objectives** of the workshop were:

- To disseminate information on best practices in primary health care services for indigenous peoples on the basis of selected experiences.
- To analyse the characteristics of practices, services and service providers regarding technical quality standards and perceptions in areas inhabited by indigenous peoples, including the incorporation of indigenous traditional medicine and practitioners.
- To identify assessment indicators to measure, i.a., the level of satisfaction among users, improvement in access and the incorporation of indigenous peoples' perspectives, therapies and medicine in health services protocols.
- To recommend actions and strategies for the development of a licensing and accreditation system for health services with an intercultural focus and consistent with the guiding principles of primary health care.



The **main results** of the meeting can be summarized as follows:

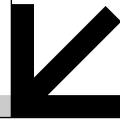
- Greater awareness and systemic collection of information regarding experiences in health services delivery in areas with indigenous populations.
- Draft contents proposal for a licensing and accreditation system for health services with intercultural focus and consistent with the guiding principles of primary health care.
- Identification of indicators to enable the assessment of health services technical quality and from the user's perspective, taking into account indigenous peoples specific characteristics.
- Identification of strategies for the development of a licensing and accreditation system for health services with intercultural focus and based on the principles of primary health care.

The results of the 2005 workshop were disseminated in order to foster recommendations for the development of a licensing and accreditation system for intercultural health services within the renewal of primary health care. The *National Workshop on Quality Standards for the Development of Intercultural Health Models in Areas Inhabited by Indigenous Peoples in Ecuador (Annex 2)* was organized in 2007. The results of these and other similar fora are compiled in this document.

1. Article 1 of ILO Convention (No. 169) concerning Indigenous and Tribal Peoples in Independent Countries (1989), considers indigenous that sector of the national community which distinguishes itself from other sectors as: "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 colonisation 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".
2. The concept of peoples refers to the set of features that characterize a human group based upon its territory, history, culture and ethnic origin, which confer the former with a sense of identity.



INDIGENOUS PEOPLES HEALTH: PRIMARY HEALTH CARE AND INTERCULTURAL FOCUS



Indigenous peoples, together with peoples of African descent and recent flows of immigration from Europe, Asia and Africa, have contributed to the results of this melting pot full of extraordinary diversity and hues that, often times, refuses to be labelled and classified in binary or contrasting “official” terms.

To overcome this self-defeating paradox, the Pan American Health Organization, through its Regional Health Programme of the Indigenous Peoples of the Americas, has developed and enlarged its action in full awareness of the need to incorporate an intercultural focus in health services delivery, based on the premise that health must be understood as a right and that indigenous peoples view of life must be taken into account. Even in emergencies when a patient’s life is at risk, we must take time to consider his or her specific characteristics, as well as those of the families, communities and peoples they belong to. This is true, particularly if the goal is to develop processes and models that emphasize disease prevention, rehabilitation and both individual and collective health promotion, taking into account the population health needs.

To this end, the practices of the so called “others” have to be revisited and ways must be found to articulate biomedical and community visions, in an effort to solve health problems generated in different contextual frameworks. This calls for a change in the current paradigms and imposes the need for an analytical exercise

driven not solely by a biomedical vision, but rather by the acknowledgment of and respect for differences and diversity.

Thus, an intercultural focus in health entails the capacity to strike the right balance between different knowledge, beliefs and cultural practices, health and disease, life and death, as well as between the biologic, social and relational aspects of health, understood not only within their visible contexts but also in the spiritual and cosmic dimension of health.

The following paragraphs include a brief overview of the practical application of an intercultural approach to health, within the context of primary health care.

Conventional analysis, in general, tend to consider population as an homogeneous body and health systems as closed orders based on the biomedical principles of conventional or Western medicine. The intercultural approach to health recognizes the importance of characterizing populations and understanding the real dimensions of peoples’ ethnicity, culture and views of the world in health dynamics.

It also stresses the importance of a more in-depth knowledge of recent and past historical events as determinants of different levels of “prestige” – usually based on imposed models and stereotypes between cultures, together with an asymmetric relation that has built up barriers of fear and mistrust. In practice, the intercultural approach to health faces the challenge of generating

spaces for communication and dialogue between cultures that could contribute to strengthen those sectors and peoples that have been excluded and increase awareness among other peoples and sectors that enjoy privileged positions.

The conventional analysis of the organizational and operational characteristics of health services usually includes a description of public and private sectors facilities and resources that are mainly based on traditional/Western medicine biomedical principles.

The intercultural approach to health recognizes the existence of formal health systems and gives visibility to informal health systems in health dynamics. In practice, these systems are interconnected, though not necessarily through conventional referral and counter-referral mechanisms, but rather by the population's preferences and real access to each one of them. **This underscores the need to examine the contexts, as well as the social, economic and cultural factors that determine the population's attitudes, knowledge and practices, in any assessment of access to health services and quality in health care. In this context, therefore, the sense of belonging to a specific community or people is all the more relevant.**

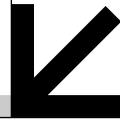
In practice, the intercultural approach to health proposes the systematic harmonization of conventional and traditional indigenous health systems

through the incorporation of indigenous peoples' perspectives, medicines and therapies in national health systems. **This will enable the adaptation of conventional health programmes to indigenous communities' realities, in a first phase.** Then, in a second phase, this will lead to the incorporation of indigenous medicine and therapies in national health systems.

Indigenous populations are usually dispersed; sometimes they are mobile and live mostly in urban marginal areas, rural and border areas, and areas of difficult access.

Collective wisdom, indigenous practices and therapists and community resources are invaluable. Nevertheless, faced with such complex epidemiological profiles, they cover only part of indigenous peoples health needs. In this sense, referring to the problems of indigenous children in the municipality of Cotagaita, in the Department of Potosí, Bolivia, the native authority expressed the following during a survey: *"... Mother Earth is very tired and needs attention in the same way in which our health and the health of our children is undermined by malnutrition, scabies, diarrhoea and other diseases, and requires medicines. We can no longer rely only on the assistance of the midwife and the wise elders, though they care for us with dedication, respect, patience and love ..."*

The already low health coverage in marginal areas sinks to extremely critical



levels in indigenous areas. In Alto Río Negro, in Brazil, for instance, there are two hospitals. The region extends over eight million hectares and the distance between hospital facilities and indigenous settlements can imply several days of travel by foot through the forest or by canoe, depending on weather conditions. Difficult physical access combined with indirect costs associated to the illness (transport, food, subsistence of the family members left behind in the village, loss of earnings, etc.) can increase the time that elapses between the first apparent symptoms of the disease and any action taken to seek health care.

This reality imposes the need to identify strategies that will bring formal health care closer to these population groups. **This implies paying diligent attention to innovative proposals related to cultural differences regarding** language and communication, values and beliefs, social organization, life styles, time conceptions and specific therapeutic resources applied at community level.

Many indigenous communities often use their **native language** as their means of daily communication among members of all ages, including children. This trend in indigenous languages is particularly evident among adult women and the elderly who are basically monolingual and are usually entrusted with the care of children.

Different signs, symptoms and illnesses are designated with terms in native languages

or in colloquial Spanish. People often simplify the diagnosis in a single word and deal with the symptom that is identified as the expression of the disease.

A quality relation between health staff and people seeking to obtain health care is crucial. Usually, health staff will limit their interaction to swift explanations about the disease or its communication patterns, its evolution and the need to follow the prescribed treatment. There is no further concern about how or if this information was understood and even less about any help the patient or his or her family might have sought from the indigenous health system. Sometimes patients are accompanied by bilingual relatives who act as interpreters, but if health staff members have no knowledge of the native language, all the information relayed rests beyond their control.

Effective capacity building for health staff remains essential. Attitudes that transpire little understanding for indigenous peoples' problems usually stem from an almost total lack of awareness about indigenous peoples' identity and knowledge. Discrimination and mistreatment are not rare vis-à-vis indigenous patients.

Human resources involved in health care services for indigenous peoples, for example, should be aware of the number of indigenous individuals living in a specific community or region, their distribution by ethnic origin, age group and sex. Technical expertise is vital; it includes, i.a. knowledge

about the epidemiological profiles of each group, the clinical evolution of a disease, methods and skills for clinical and lab diagnosis, basic notions of entomology and, particularly, knowledge about the population and the determinants that have an impact on indigenous peoples' life styles and health status.

Obviously, it is important to count on an adequate stock of medical supplies consistent with the epidemiological profile of the community and to strengthen the local managerial capacity to cope with emergencies and enhance health promotion as a component of the social and economic development of the community.

In fact, it must be noted that the epidemiological profile data and the available information on living and health conditions, in general, do not come from homogenous sources. Only a few countries systematically gather and analyze vital and services statistics by ethnic group and, even fewer of them, **submit disaggregated data by ethnic group and gender**. This explains the difficulty in obtaining information for an adequate assessment of the health status, living conditions and health services coverage of the more than 45 million indigenous people living in the Americas.

In spite of these limitations, specifically at the level of indigenous peoples' places of origin and settlement we find a fairly well documented reality that finds agreement among all those countries that participated in the Decade of the World's Indigenous

Peoples survey, i.e., that this is where the deepest and most abhorrent inequities in terms of poverty and extreme poverty are found, where percentages regarding lack of vital services, mother and child mortality rates, malnutrition and infectious diseases are astounding beyond discussion.

It is not easy to pinpoint in indigenous territories the gradual destruction of ecosystems due to the overexploitation of natural and mineral resources, the changes in life dynamics introduced by successive waves of settlers and unbridled colonization, works associated to development and changes in settlement patterns under the pressure of advancing living frontiers. When we add to this the lack of real political participation that precludes these peoples' visibility as social stakeholders and actors in their own countries' development proposals, a clearer and more complete picture emerges regarding the determinant factors of real poverty conditions and the health impacts for indigenous peoples' health. Indigenous peoples' marginality is further compounded by the lack of land and territory, low salary and significant rates of unemployment.

In this rather dire social and economic context, with rare exceptions the overall health status of indigenous populations in the Americas is quite alarming. The most deadly diseases are malaria, onchocerciasis, acute respiratory diseases, tuberculosis, diarrhoeal diseases, malnutrition, alcoholism, drug abuse, chronic and degenerative diseases, AIDS and suicide.



Unfortunately, mortality and morbidity rates are highest among children. The specific characteristic of these populations lead to believe that mortality and morbidity data are probably higher than reported since numerous births and deaths are not registered or not specifically disaggregated by ethnic origin. These are aspects that should be taken into account when assessing progress in the achievement of the Millennium Development Goals, in general, and the infant mortality rate reduction goal, in particular.

In Bolivia, the average infant mortality rate is 102 per 1.000 viable births in 51 rural municipalities with over 50% of indigenous women who are monolingual; this is over twofold the comparable rate of the general population (54 per 1.000 viable births). In the Northern Region of Argentina, malnutrition is the main cause for indigenous children mortality and morbidity; 80% of such malnutrition cases is linked to parasitosis due to precarious sanitation conditions.

According to a baseline survey on mother mortality rates carried out in Guatemala in 2000, this country –with 42% of indigenous population, has one of the highest mortality rates among mothers in Latin America. These percentages are even higher among indigenous women, at 211 per 100,000 viable births, i.e. three times higher than among non indigenous mothers (70 per 100,000 viable births). The mortality rate associated to pulmonary tuberculosis among indigenous peoples is

twofold that of the general population in Mexico and between eight to ten times higher than the general average in Canada.

These few statistics can illustrate the magnitude of the problems faced by indigenous peoples in the Americas; therefore, we acknowledge the importance of quantitative data and research. However, only qualitative research will set the right context for this figures and provide further insights into processes of the health-disease equation as perceived from indigenous peoples' view of the world.

Despite the diversity of indigenous peoples, it is possible to identify common denominators that could be helpful in tracing the main tenants of their psyche. Several researchers, such as Yáñez del Pozo, argue that indigenous peoples, peoples of African descent, and other cultures around the world consider harmony between individuals and the Universe as the source of health and the ideal of life. For instance, **Andean indigenous peoples' mental structure is based on pairs or dualities: hot and cold, high and low or male female. They are moved by a deep respect for ancestors, forefathers and spirits.**

Rituals emerge at this level of the mental structure and become part of both ordinary and special events throughout a person's life. Such is the case at conception, birth, the rituals regarding the placenta, the umbilical cord and the navel, the name-

giving ritual, the first haircut, the first nail cut, and the rituals and ceremonies organized to mark these moments. The encounter with death is described as a transition process towards other worlds.

Duality is illustrated by a study carried out among the Desana people, a member of the Tukano family of peoples in the Brazilian Amazon Region. The study reported that the Desana classified diseases into white-men diseases and traditional diseases. The former are extremely virulent, acute and transitory, with short incubation and infectious periods and highly communicable, while traditional diseases are endemic and usually chronic in their evolution (Buchillet, 1995). Thus, tuberculosis, for instance, in its diverse forms (pulmonary and non pulmonary), is considered a traditional disease, this is, it has always existed in the community. Furthermore, tuberculosis is associated to witchcraft and, hence, it is not considered a contagious disease.

How should we interpret all this? Are conventional medicine and indigenous medicine rationales really that different? **In practice, indigenous users and users from other cultures seem to demonstrate that these are supplementary approaches. Community wisdom will be helpful in understanding the way disease is perceived and, therefore, how it should be addressed. This area of knowledge is just starting to be developed in health sciences and is scantily incorporated in operational health services.**

Several ethno-botanic studies report the use of medicinal plants to treat and control several diseases. Nevertheless, it is commonly agreed that further research is required to identify and verify the safety and effectiveness of such treatments.

Finally, in their efforts geared towards the improvement of indigenous peoples' health, we urge countries to take into account both the domestic and international legal frameworks for action, as well as indigenous peoples' participation and community involvement.

Among other international instruments are ILO Convention 169 (1989), the UN Declaration of the I Decade of the World's Indigenous Peoples (1994), the UN Declaration of the II Decade of the World's Indigenous Peoples (2005), the Universal Declaration of Indigenous Peoples Rights, adopted by the UN Human Rights Council, on June 29, 2006, PAHO/WHO Resolution CD37.R5 (1993), Resolution CD40R6 (1997), Resolution CD47.R18 (2006). Particularly significant are in this sense and above all, the legal progress achieved at country level to facilitate a respectful approach to indigenous peoples realities and health systems. This has enabled the incorporation of and intercultural approach to health through the harmonization of national and indigenous health systems.

Both at domestic and international level, the leadership and constant activism of indigenous peoples to protect their rights have been decisive in the development,



ratification and implementation of these agreements, declarations and conventions.

Indeed, illnesses are overcome when the individual and the community are aware of their rights, exercise them and take control over their own wellbeing. This assertion is not new, in 1978, more than 25 years ago, in the Alma Ata Declaration, the International Conference on Primary Health Care, already stated that primary health care requires and promotes maximum community and individual self-reliance and participation in the planning, organization and operation and control of primary health care. Technical teams, who must respond to the needs of indigenous peoples, should carefully take into account the community's vital and cultural perspectives.

Needless to say that an adequate approach to this problem should not be restricted to initiatives in the health sector and demands sound intersectoral alliances. In recent years PAHO has stressed the need for official bodies to retrieve the holistic approach to health proposed by indigenous peoples. Under indigenous peoples' view of the world, all elements in the universe are interrelated and the so-called social determinants of health would only be a set of different aspects and components required to strike this much-sought-after balance. However, in this equilibrium not everything revolves around the individual, nor everything is explained by an immediate physical wellbeing.

It might not be easy to find solutions for structural problems. Nonetheless our commitment is, and must be, to take into account in our work the concepts and practices of millenary peoples who understand health as a result of a right balance between all aspects of life: economic, political, cultural, spiritual and environmental. This must be translated in the daily interaction with indigenous persons and patients, through decent treatment that would take into account indigenous peoples' knowledge, expectations, hopes, fears, emotions, pain and anxiety in the way they deal with disease and death. The dialogue we propose based on an intercultural approach to health would contribute to further progress in the construction of the type of citizenship that would incorporate the different perspectives of indigenous peoples living in the Americas.



VALUES AND PRINCIPLES OF RENEWED PRIMARY HEALTH CARE



The World Health Organization (WHO) has been promoting primary health care (PHC) since before it was adopted, in 1978, as a core strategy in the achievement of the “Health for All” goal. The world and primary health care have dramatically changed since then. The aim in renewing primary health care is to instil new dynamism at country level to design a joint, effective and sustainable strategy to address existing health problems.

Some of the reasons that justify the renewal of primary health care include, i.a., new epidemiological challenges, new knowledge and tools on best practices that could be tapped to increase the efficiency in the delivery of PHC services, the growing recognition of PHC as capacity building tool to reduce health inequities.

The average values of health indicators in almost all countries in the Americas have improved, for instance, child mortality rates have dropped by almost one third, all-cause mortality rates have decreased in 25% in absolute terms. However, considerable and relatively new challenges remain and continue to grow, such as HIV/AIDS and other infectious and communicable diseases. Furthermore, there are region-wide economic and social changes that have health impacts such as obesity, cardiovascular illnesses, smoking, alcoholism, drug abuse and other ailments linked to changes in lifestyles, unbridled urbanization, disaggregation of the family core and disintegration of the community as a social reference, among other detonating elements.

Particularly during the previous decade, economic readjustment practices, globalization pressures, together with the impact of free market theory orthodox policies, contributed, among other factors, to the unfair distribution of wealth and asymmetries in power exercised by a minority. This contributed to further exacerbate inequities: health services delivery, among others.

Our understanding of health has gradually expanded and so has the awareness regarding the limitations of conventional health systems to respond to the population’s needs. In the region, there is often the perception that “health is an event with political, economic and social implications which, above all, it must be viewed as a fundamental right. It is considered that inequality, poverty, exploitation, violence and injustice are some of the root causes of deficient health conditions and death among poor and marginalized groups.”³

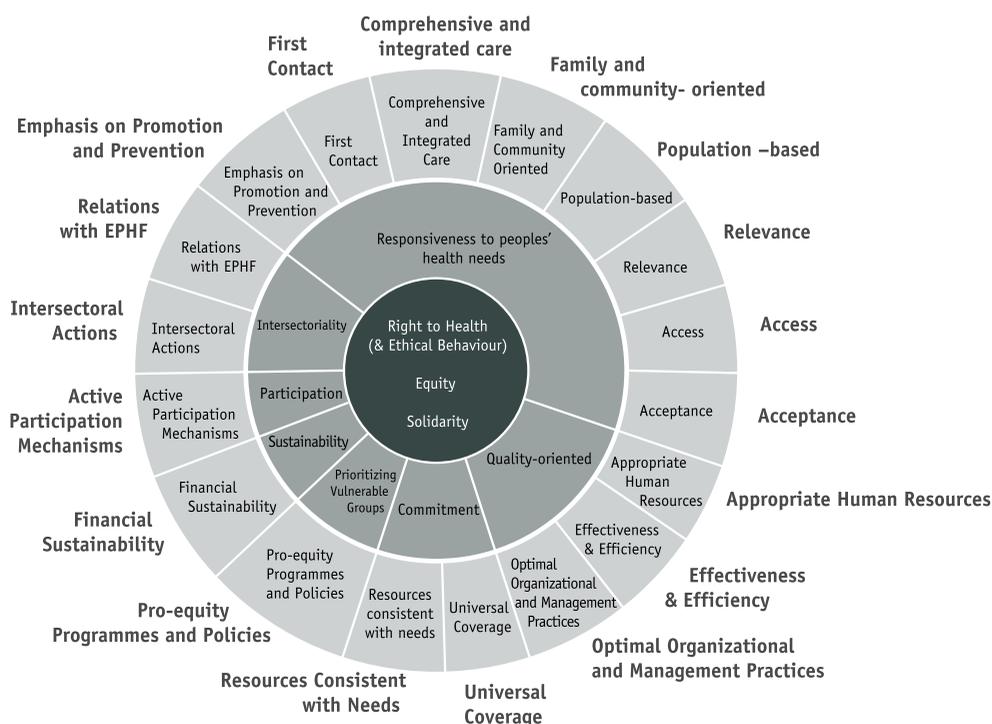
If the previous statement is to be considered true, then any approach to health improvement must be developed within a comprehensive and clearly established economic, social and political context, with the participation of civil society.

A primary health care-based health system must have a legal, institutional and organizational framework, as well as adequate and sustainable human, financial and technological resources.

The essence of the renewed definition of PHC is the same as in the Alma Ata Declaration. However, this new definition focuses on the health system as a whole; it includes private, public and non-profit sectors. It differentiates values, principles and elements; it highlights equity and solidarity, and incorporates new principles such as sustainability and a quality orientation.

The approach presented here is meant to serve as a guideline in the organization and structured understanding of a PHC-based health system. As appropriate, each country will need to design its own strategy for PHC renewal consistent with its degree of development.

The following figure presents the values, principles and elements of a PHC-based health system.





A. VALUES

Values are essential for setting national priorities. They provide a moral anchor for policies enacted in the public interest and to benefit the population as a whole.

a. The right to the highest attainable level of health is instrumental in assuring that health services are responsive to people's needs, that there is accountability in the health system and that PHC is quality-oriented.

b. Equity in health addresses unfair differences in health status, access to health care and health-enhancing environments. Equity is the cornerstone of social values; the way in which societies treat their most disadvantaged members reflects the value conferred to human lives.

c. Solidarity is the extent to which people in a society are committed to work together to achieve common good. PHC-based health systems require social solidarity to ensure the sustainability of investments in health.

B. PRINCIPLES

PHC-based health systems are built on principles that provide the foundations for health policies, evaluative criteria, resource generation and allocation, and the operation of the health system.

a. Responsiveness to peoples' health needs implies that health systems must be centred on human beings and should try to meet their need to the fullest extent possible. PHC must attend to the population health needs regardless of their socioeconomic status, culture, race, gender or ethnicity.

b. Quality-oriented services have the capacity to anticipate the population's needs and treat all individuals with dignity and respect. This requires providing health professionals at all levels with evidence-based clinical knowledge and with the necessary tools to continuously update their training. Quality orientation also calls for adequate procedures to assess the efficiency, effectiveness and safety of preventive and curative health interventions.

c. Government responsibility and accountability assures that social rights are guaranteed and enforced by any government and that citizens are protected from any violation of their rights. This principle is applicable to all health systems functions, regardless of the type of service provider (public, private, non-profit). The different levels of government need clear areas of responsibility and accountability mechanisms.

d. Social justice suggests that government actions, in particular, must

be assessed by the extent to which they ensure the welfare of all citizens, specially the most vulnerable.

e. Sustainability of the health system requires strategic planning and long-term durable commitments. A PHC-based health system is the main means for investment in any population's health.

f. Participation turns people into active partners in decision-making processes concerning the allocation and use of resources, the definition of priorities and ensuring accountability.

g. Intersectoriality in health means that the health sector must work alongside with other sectors and actors to ensure that public policies are aligned to maximize their potential contribution to health and human development.

3. *People's Health Movement, editor. Health for All Now Revive Alma Ata. The Alma Ata Anniversary pack 2003. Unnikrishnan, Bangalore (India).*





CONCEPTUAL
APPROACH
TO HEALTH,
INTERCULTURAL
FOCUS, QUALITY,
ACCESS, LICENSING,
ACCREDITATION
AND PRIMARY
HEALTH CARE



In 1978, the Alma Ata Declaration defined Primary Health Care as 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 and at a cost that the community and country can afford to maintain. It forms an integral part of both the country's health system and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process.

There are several definitions of **quality in health services delivery**, among others, the following:

Avedis Donabedian: "The use of the most appropriate means at a level that enables the achievement of optimum improvements in health". *Otero, A*: "The provision of equitable and accessible services at optimum professional level and with minimum risk for patients, taking into account available resources and achieving users' support and satisfaction". For the *Joint Commission on the Accreditation of Health care Organizations (JCAHO)* quality in health services is the degree of health services provided to a patient which increases the probability of the type of results expected by the latter and reduces the

probability of adverse outcomes due to the level of knowledge available.

Regulating instruments of quality in health care services include: accreditation, categorization, licensing and self-assessment programmes.

Licensing is a legally-based compulsory procedure through which health authorities – according to their jurisdiction, grant operational permits to public or private health services providers after verifying their compliance with the established requirements or standards.

Accreditation is the procedure through which institutional resources are voluntarily, periodically and reservedly assessed in order to ensure quality in services on the basis of previously accepted standards. Standards can be minima (baseline) or more elaborate and stringent, according to different levels of satisfaction. It could be said that a health care facility "grants" or "receives" accreditation when the organization and management of its activities and resources make up a process ultimately aimed at achieving adequate quality in health care as the final result.

Categorization is the classification of the ambulatory and admissions effects on the basis of specific criteria (complexity, health care risks, or others). Levels are thus established, activities concentrated and services classified as per the feasibility of their delivery according to the type of facility. It facilitates the creation

of networks of services in local health systems.

Self-assessment programmes are based on explicit and acceptable performance criteria which are compared with the actual services delivered. Post-mortem anatomy and pathology meetings, clinic cases discussions and medical records reviews are also part of institutional assessments. Referrals and counter-referrals within the health services networks using tracing indicators, clinical sequels and individual satisfaction of patients and their families are other examples of assessments.

Therefore, the general basic steps to strengthen and improve the quality of services in a health facility include:

- **Licensing** would be the first step in setting up a health care facility.
- **Accreditation** would gradually improve institutional quality in health care.
- **Categorization** will provide the determinants for health services that can be delivered and the creation of health facilities networks.
- **Self-assessment methods** are specific internal institutional procedures.

In recent years, the most significant changes in quality-assurance plans have occurred at regional level. In Spain, for instance, each region has chosen its own accreditation model: Galicia has published

a manual on hospital accreditation standards grouped by services or health care specialty (pathology & anatomy, image-based diagnosis, etc.); Cataluña bets on a new accreditation system based on the model of the European Foundation for Quality Management (EFQM) that combines JCAHO and ISO standards; while Osakidetza does not have its own accreditation system but customs the EFQM model as a basis for health centres development. Other communities have selected less well-known approaches: Andalucía applies a “trans-system” quality model that integrates health services provided at different levels based on certain key processes and their evaluation.

These examples illustrate the current world trend towards the dispersion of accreditation models. In recent years, several countries, such as France, have developed a single accreditation model. Needless to say that, this fragmentation of accreditation models will impose the need for significant efforts in the future to achieve harmonization.

From the users’ point of view, on the other hand, there is often an array of expectations or aspirations that eventually form the basis for a concept of quality in health care services. Patients’ wish-list usually includes:

- Understandable information
- Specifically defined degree of participation in decision-making



- Access to complete clinical records and medical history
- Right to seek a second opinion
- Communication with health services outside pre-established medical appointments.

Thus, patients should always be provided with the most accurate and complete information about diagnosis procedures, analysis, exams and other tests they are submitted to, as well as about any ensuing treatment. They must enjoy full and free access to their clinical records –something which is not always feasible due to internal administrative policies, though they are usually required when seeking a second opinion regarding a diagnosis or a prescribed treatment.

Quality, in general, and in operational terms in particular, is defined as “the characteristics of a good or service that meet the expectations and needs of a customer or user”. In operational terms, quality in health services implies “providing the beneficiaries of health services the assurance that they will receive the greatest possible benefits and that they will be protected from unnecessary risks”. In this sense, quality has both a technical dimension and a dimension associated to the user’s or patient’s perception. Technical quality is linked to safety, effectiveness and usefulness of health care and perceived quality is linked to acceptability and warmth, in other words, it is associated

with dignified treatment for patients and users. In sum, it means “doing the right things, the right way”. (Muir Gray, in Infante A. *Garantía de la Calidad*. Power Point presentation, PAHO, 2005).

The main attributes of quality-oriented health care services delivery are effectiveness, efficiency, acceptability, legitimacy and equity.

- Effectiveness refers to the system’s capacity to achieve health improvements.
- Efficiency implies the capacity to reduce health care costs without jeopardizing health improvements.
- Acceptability means consistency and responsiveness to the patients and their families’ wishes and expectations.
- Legitimacy implies consistency with social preferences expressed through ethical principles, values, standards, laws and regulations.
- Equity implies consistency with the principle of the fair distribution of health care services and their benefits among all members of the population⁴.

Accessibility is one of the dimensions of quality in health care. It is related to the ease with which the population can receive the care it requires. This dimension considers structural (e.g. opening hours, distances) and economic barriers, as well as organizational, social and cultural

obstacles. It also encompasses equity, understood as the fair distribution of health resources among the population.

Real access to health care services in Latin America and the Caribbean can be illustrated with the following data:

Out of the 500 million inhabitants that form the total population in Latin America and the Caribbean (LAC):

- 27% has no permanent access to basic health services (125 million)
- 46% has no health insurance (230 million)
- Nearly 120 million people have no access to health services due to economic reasons.

Additional indicators highlight that:

- 107 million people lack access to health services due to geographical reasons
- 17% of the total number of births in LAC are not attended by qualified health professionals
- 82 million children have not completed their vaccination programmes
- 152 million people lack access to drinking water supply and basic sanitation⁵.

The main barriers in access to health services in the Region have been identified as follows:

- Cultural barriers
 - Language
 - Knowledge, attitudes, beliefs and practices
- Social barriers
 - Education level
- Economic barriers
 - Fees for services, personal disbursements
- Geographical barriers
 - Distance from health services
- Perceived quality of services
 - Hospitality, availability of medicines, service hours, waiting periods, etc⁶.

Different sectors contacted in a number of countries during technical cooperation missions (MOHs, academic institutions, indigenous peoples organizations, NGOs, PAHO/WHO Country Offices) have expressed concern regarding an array of complex factors – such as cultural, social, economic and geographical barriers, that result in low levels of access to and use of public health services by urban marginal demographic groups. They have also recognized the contributions brought about by indigenous knowledge, practices, resources and practitioners to improve the health status of these groups, as well as the need to find adequate strategies and



fora to strengthen the former and promote a respectful and supplementary interaction between indigenous and official health systems.

Cultural barriers stem from a lack of understanding of cultural contexts. These often regard highly certain cultures to the detriment of others and, thereby, determine the place that each culture occupies within national societies. Culture could be defined as a pattern of characteristic beliefs, thoughts, values, practices, communication, behaviours, view of the world and institutions (e.g. family, economic, political and religious institutions) that enable the preservation of a specific social group. Ethnicity, race, geographical environment and socioeconomic level, in different combinations, make up different cultural contexts.

Public services do not take into account differences between cultures regarding language and communication, values and beliefs, lifestyles and time conceptions. In turn, this creates organizational barriers in health services, translated in problems linked to health staff performance, opening hours, physical positioning and technical procedures used in public health services. Each one of these aspects represents as many inconsistencies between health services organization and delivery and the internal dynamics of multicultural peoples.

Social barriers are determined, for instance, by the level of education. Illiteracy rates among indigenous

peoples are high, particularly among women. Economic barriers are linked to the financial difficulties people face to have access to health care due to their income level, the real costs of health services (transportation, food, lodging, medicines, loss of income), specially during emergencies. Furthermore, several indigenous communities use bartering as a means of payment, while this mechanism is not usually accepted by non-indigenous societies. Geographical barriers are related to the difficulties people face in seeking access to health care due to distances from health facilities, means of transport and seasonal geographical isolation.

Access is defined in terms of geographical viability. It has been established that urban population enjoys access to public health care services when the nearest facility is thirty minutes away in urban environments and one hour away in rural contexts. Nonetheless, it is suggested that this definition should also encompass problems related to cultural and economic barriers that condition people's real access to health services.

Any proposed standards and elements for a licensing mechanism for health services should take into account the legal framework that promotes equity and that should be applied in the management and implementation of existing rules and regulations, evidence-based protocols and institutional strategies aimed at assuring, for instance, the adequate provision of medical supplies.

Another criterion for standard-setting is related to managerial, professional, technical, administrative and support staff training and efficiency. An additional indicator could be the number of nurses per patient. There is a pressing need for health managers who understand indigenous knowledge, who are familiar with practices used in indigenous medicine and therapies and who should work closely with conventional health professionals as a team.

It is crucial to have health facilities whose physical infrastructure is designed for the admission and accommodation of both patients and their accompanying relatives or friends, particularly if the patient is indigenous. Such facilities should be built taking into account the habits and traditions of this population group.

Health equipment must meet technical standards consistent with the health facility's level of complexity, in such a way that indigenous patients stay is facilitated by making them feel comfortable and considered through the respect shown for their habits and traditions. This shall result in improved levels of health care and satisfaction among patients.

Under this proposal, health facilities management, infrastructure, equipment and human resources are all contributing factors in the final results of quality assessments in health services delivery.

The following table present the weighed importance of each component based on the health facility's level of complexity:

Weighed importance by component and level of complexity

Component	PS	SCS	CS
Management	20%	10%	10%
Infrastructure	10%	40%	40%
Equipment	30%	20%	30%
Human Resources	40%	30%	20%
Total	100%	100%	20%

PS: Puesto de Salud; SCS: Sub Centro de Salud; CS: Centro de Salud



The incorporation of the intercultural approach to health aims at strengthening non dominant cultures and raise awareness among dominant cultures by emphasizing their similarities and promoting a multi-angled learning process.

In intercultural paradigms, the concept of intercultural focus implies an interactive social process that –within a specific context, encompasses acknowledgement of and respect for political, economic, social, cultural, linguistic, gender and generation differences within and between cultures, and which is a vital foundation for a fair society (PAHO, 1998). In the implementation of the social participation principle, supported by the health sector reform, the application of the intercultural approach to health must be based on dialogue, respect for diversity, democracy and participation with cultural interaction, consultation, consensus and goal-oriented collaboration (PAHO, 1998).

The aim of this process is to contribute to the equitable access to quality health care translated in the timely, efficient and safe delivery of health services (technical quality), in an adequate physical environment, with appropriate ethical standards and warmth that reflect acceptance towards the user and his or her dignified treatment in health care services delivery (perceived quality) (Omram, 1997; PAHO, 1998; PAHO, 2005).

Some of the main recommendations that should be incorporated by countries in

the Region in their policies on health care services delivery with intercultural approach include:

- To equitably apply the concept of comprehensive health based on the biological, sociological and spiritual balance of human beings –which stems from the holistic approach to health proposed by indigenous peoples themselves, and which promotes the harmonious development of society and peoples’ right to self-determination.
- To face the challenges of the incorporation of indigenous peoples’ vision by including in legal frameworks, rules and regulations the need to value the ancestral knowledge of original peoples until levels of awareness similar to those enjoyed by Western knowledge are reached.
- To further train and strengthen capacity building among indigenous human resources in order to increase the number of indigenous health professionals who work at community level.
- To improve important evidence-based managerial processes by urgently modifying health information systems in order to incorporate ethnicity data, among other variables.
- To prioritize local capacity-building as the goal of the decentralization in health decision-making processes in general, and regarding the health of indigenous peoples in particular, at local, district and national level.

- To develop conscience-awareness strategies to overcome resistances among health professionals and workers within the health system.
- To include the participation of indigenous leaders and wise people in health services management in order to promote adequate accreditation processes of recognized traditional indigenous medicine practitioners.
- To avoid the risk of divisions in indigenous leadership associated to changes introduced to incorporate an intercultural approach to health services delivery.
- To promote programmes aimed at strengthening indigenous peoples' identity and value.
- To encourage and enhance intersectoral actions to strengthen indigenous peoples' presence in national affairs and to generate coordinated actions as a response to complex indigenous problems not circumscribed to the health sector.

4. Source: Avedis Donabedian, Adapted by JL di Fabio
5. JL Di Fabio, power point presentation, PAHO, 2005
6. JL Di Fabio, power point presentation, PAHO, 2005



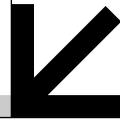
05_





HEALTH SERVICES DELIVERY IN AREAS INHABITED BY INDIGENOUS PEOPLES:

PRIMARY HEALTH CARE AND
INTERCULTURAL FOCUS IN
BOLIVIA, BRAZIL, CHILE,
ECUADOR, MEXICO, PANAMA
AND VENEZUELA



One of the objectives of the workshop organized in November 2005 was to exchange experiences on health services delivery in areas inhabited by indigenous peoples in countries of the Region. The idea was to present different approaches, methods and concepts from contrasting but, nonetheless, important angles.

The experiences presented are summarized in the following pages.

• **BOLIVIA**

The experience presented concerned the *Ayllus* Project developed for six communities in La Paz. The project included the construction of a health centre where both traditional and conventional medicine are applied, the implementation of community pharmacies and other services, as well as training for indigenous staff that join the health centre.

Country	Bolivia
National context	<ul style="list-style-type: none"> • Surface: 1.098.581 sq km. • Population: 8.274.325 inhabitants. • Demographic density: 7.5 inhabitants x sq km. • Life expectancy at birth: 63.3 years (2001) • GDP per. Capita: 936 USD. • Poverty incidence rate: 64.5% • Extreme poverty rate: 36.6% • Literacy (aged over 15 years): 86% • 60% of the population has less than 25 years of age • Only 7% is older than 65 years • 62% of the population lives in urban areas • 56% belong to the Quechua or Aymara peoples • 6% is Guaraní • 11 % speaks only their native language
Current constitutional principles	<ul style="list-style-type: none"> • Process underway to enact a new Constitution (Constituent Assembly) • Growing demand for structural changes in the country's social policy.

<p>Legal framework & Competence of the Health Sector</p>	<ul style="list-style-type: none"> • 1987. Regulation on the practice of natural traditional medicine, approved by Ministerial Resolution N° 0231, on March 13, 1987. • 1998. Basic Health Insurance established by decree DS 2526, on December 31, 1998. • 2001. Regulation on Basic Health Insurance, approved by Ministerial Resolution N° 0182, on May 10, 2001. • Art.6. The basic health insurance system provides coverage throughout pregnancy and for any complications, as well as for prevalent diseases among under five year olds and among the general population. • 2001. Standards for natural, traditional and homeopathic medicines defined by Ministerial Resolution N° 0013, on January 16, 2002. • 2002. National Health Policy & Strategies: primary health care, co-management, social inclusion, non-discrimination in healthcare for original peoples. • Indigenous and Original Peoples' Health Insurance created by supreme decree D.S. N° 26330, on January 18, 2002. • 2002. Universal Mother and Child Insurance (SUMI) is established by Law 2426, on November 21, 2002. Art. 8 on customs and traditions. • 2002. Universal Mother and Child Insurance Regulation, establishes local health steering committees (DILOS), supreme authority in "co-management of health services with community participation", in compliance with the National Health Policy, the Universal Mother and Child Insurance implantation and the application of priority programmes identified by municipalities. (Art. 7. II) .
<p>Changes in socioeconomic vision</p>	<ul style="list-style-type: none"> • Neo-liberal model challenged and new economic foundations established.
<p>Type of experience</p>	<ul style="list-style-type: none"> • Local
<p>Summarised description of the experience</p>	<ul style="list-style-type: none"> • Comprehensive Strategic Development Plan - <i>Ayllus</i> in La Paz: Project involving six communities in the Municipality of Pocoata, Department of Potosí. The objective was to build a health centre where both traditional and conventional medicine health services would be provided and the work of traditional health practitioners and midwives would be recognized. Community pharmacies and other specific actions were also implemented with the participation of indigenous students and professionals.
<p>Final objective of the experience</p>	<p>Construction of the health centre where both traditional and conventional medicine visions are applied.</p>
<p>Facilitating factors</p>	<ul style="list-style-type: none"> • Community participation in decision-making • Acknowledgement of organization according to traditions and customs • Commitment from municipalities, prefect's office, international cooperation agencies, etc. • Legal framework and social monitoring and oversight.



<p>Obstructing factors</p>	<ul style="list-style-type: none"> • Mistrust towards State actions • Assistance-dependent vision among certain authorities • Geographical barriers • Territorial reality vs. political/administrative division • History of rivalry • Social and political context • Incomplete information system • Ministry of Health & Sports programmes lacked intercultural focus • Directorate of Traditional Medicine and Intercultural Focus with no regional representation • Poor quality assessment • Lack of State policies
<p>Recommendations</p>	<ul style="list-style-type: none"> • Participation of indigenous peoples in public policies management at the level of the Ministry of Health & Sports • Integrated approach to problems • Accreditation processes for traditional medicine practitioners should be undertaken • Multisectoral and inter-institutional actions • Development of a specific legal framework • Definition of satisfaction parameters by users.

• **BRASIL**

The Ministry of Health provides services directly and through the National Health Foundation (FUNASA), that coordinates, regulates and implements health care actions, abiding by the principles and guidelines on the Single Health System. This is a nation-wide experience in which there is a decentralized and regionalized system for basic healthcare in indigenous territories operating under a mechanism of indigenous districts. The health system includes medium and high complexity facilities in coordination with local municipalities. Planning and oversight are strengthened through Indigenous Councils

and Health Conferences (convened at local, district and national level).

The implementation of such large infrastructure in a country of vast dimensions requires sophisticated equipment and complex supply systems. Favourable factors for positive results in managing this process include: training of health staff; capacity-building for indigenous personnel who are knowledgeable in traditional health practices and who respect indigenous customs and traditions; community participation and; the support of district authorities and NGOs.

Country	Brasil
National context	<ul style="list-style-type: none"> • Indigenous population: 445.103 0.3% • Indigenous territories: 580 • Ethnic groups: 210 • Native languages: 170 • Villages: 3.726 • Municipalities: 379 • 34 Special Indigenous Health Districts (DSEI)
Current constitutional principles	<ul style="list-style-type: none"> • The Federal Constitution recognizes the specific ethnic and cultural characteristics of indigenous peoples and establishes their social rights. Main articles: Arts. 231 and 232, Chapter VIII (Indigenous Peoples), under Section VIII (Social Order). • Art. 231. Indigenous peoples' social organization, customs, languages, beliefs and traditions are recognized, together with their original rights over the lands they traditionally occupy. It shall be the Union's responsibility to delimit such territories, protect and ensure respect for all their assets.



<p>Legal framework & Competence of the Health Sector</p>	<p>National Policy</p> <ul style="list-style-type: none"> • National Policy on Health Care for Indigenous Peoples, approved by decree MS No. 254, on January 31, 2002. • Management Guidelines regarding the National Policy on Health Care for Indigenous Peoples, approved by decree 070/GM, on February 20, 2004. • The Indigenous Health Sub System under the Single Health System was established by Law No.9.836, on September 23, 1999. It includes a specific supplementary chapter to Law 8.080, of September 19, 1990, on the Single Health System. This law is regulated by decree No. 3156, of August 27, 2004. <p>Relation with the Single Health System</p> <ul style="list-style-type: none"> • Decree MS No.1163, of September 14, 1999, establishes several mechanisms for relations between the subsystem and other components of the Single Health System. • Special Indigenous Health Districts • FUNASA decree No.852, of September 30, 1999 creates the Special Indigenous Health Districts and their structures. FUNASA Internal Regulations place them with its organizational structure.
<p>Type of experience</p>	<ul style="list-style-type: none"> • National
<p>Summarized description of the experience</p>	<ul style="list-style-type: none"> • Brazil has a Single Health System and an Indigenous Peoples Health Subsystem. Basic health services operate in indigenous territories under a decentralized model of regional indigenous districts. The system includes medium and high complexity facilities in coordination with local municipalities. Planning and monitoring functions are strengthened through Indigenous Councils and Health Conferences (convened at local, district and national level). The mechanism has an information system. • Operationally, each Special Indigenous Health District (DSEI) is composed of a health post located at village level, base health poles with larger geographical coverage and multidisciplinary health teams and an Indigenous Health House (CASAI) where medium and high complexity cases are referred to within a certain jurisdiction. In each health district, each network is clearly identified and organized. • The main health interventions include immunization, nutritional status surveillance, comprehensive health care services for women, water supply and sanitation, oral health, tuberculosis and malaria.
<p>Final objective of the experience</p>	<p>Assure comprehensive health care services to help indigenous populations in overcoming the risk factors that affect them. Institutionalization of rights.</p>
<p>Facilitating factors</p>	<p>Social control and monitoring</p> <ul style="list-style-type: none"> • Training for indigenous professionals and health workers.

Obstructing factors	<p>Difficulty in achieving appropriation by human resources in service management and implementation.</p> <p>Centralized administrative processes.</p> <p>Confusion regarding the role played by indigenous organizations: representatives taken as service providers.</p> <p>Difficult coordination of health care at medium and high complexity level.</p>
Other contributions	<p>Management model developed: Special Indigenous Health Districts are the leading authorities in indigenous territories.</p> <p>Recruitment mechanism for health managers establishes in Special Indigenous Health Districts.</p> <p>Information system incorporates ethnicity as a variable.</p>

• **CHILE**

The Republic of Chile presented a local experience specifically focused on the Aymará people, which had 48,501 members in 2002. The project was implemented in the Maternity Ward of the Iquique Hospital. The unit has an intercultural health team in which midwives are involved in prenatal

health controls and childbirth; thus, Western and Aymará visions are shared in a climate of mutual trust and cross-fertilization. In an adequate environment where privacy and intimacy are respected, mothers walk around freely accompanied by their husbands or relatives and can drink herbal teas and choose the childbirth position they prefer.

Country	Chile
National context	<ul style="list-style-type: none"> • Aymara Population: 48,501 (2002 census) • Population of women of fertile age: 3,694
Current constitutional principles /national policies	<p>Law on Indigenous Peoples N° 19.253 D. of 5.10.1993⁷</p> <p>State Policy on Indigenous Peoples⁸. “Historical Truth and New Treatment”, 2004.</p>
Legal framework & Competence of the Health Sector	<p>Policy on Health and Indigenous Peoples, 2003⁹.</p> <p>Health Authority Law N° 2763, 2004¹⁰.</p>
Type of experience	<ul style="list-style-type: none"> • Local (pilot) experience



Summarized description of the experience	<ul style="list-style-type: none"> • The project has an intercultural health team in which midwives are involved in prenatal health controls and childbirth; thus, Western and Aymará visions are shared in a climate of mutual trust and cross-fertilization. • In an adequate environment where privacy and intimacy are respected, mothers walk around freely accompanied by their husbands or relatives and can drink herbal teas and choose the childbirth position they prefer.
Final objective of the experience	<ul style="list-style-type: none"> • The aim of the project is to improve the technical quality of prenatal controls and childbirth for Aymara women of rural communities and increase the level of satisfaction among users through the implementation of an intercultural health model in the Maternity Ward of the Iquique Hospital.
Facilitating factors	<ul style="list-style-type: none"> • The community feels more identified with this space where its contribution is appreciated and its members have started to trust staff who will help them if they so require. • Indigenous medicine practitioners, and particularly midwives, follow closely the experience (and contribute to its dissemination). • The results of this experience have encouraged professionals to become part of this and other similar complementary initiatives to benefit the population. • Users and their families satisfied with the experience have been associated to the model enabling social monitoring.
Recommendations	<ul style="list-style-type: none"> • User-centred health care with due respect users culture and responsiveness to their needs and expectations. • Definition of culturally-relevant quality standards. • Network. Referral and counter-referral systems that take into account both health systems.

7. Law on Indigenous Peoples N° 19.253 regarding the protection, enhancement and development of indigenous peoples, enacted on October 1993. It establishes the recognition, respect for and protection of indigenous cultures and languages, the use and preservation of indigenous languages, alongside Spanish, in areas densely populated by indigenous peoples.
8. Government policy as a result of the work of the Commission on Historical Truth and New Treatment, officially enacted by President Ricardo Lagos through decree DS N° 19, on January 18, 2001.
9. Policies on Health and Indigenous Peoples, Ministry of Health, Nation Health Fund, Programme on Health and Indigenous Peoples, Government of Chile. January 2003.
10. Incorporation of indigenous peoples as a priority group in the Public Health Plan. Continuity in the work on health and indigenous peoples under the new health deputy secretariats of public health and health care networks.

• **ECUADOR**¹¹

The experience presented concern the Community Health Project for the Northern Amazon Region in Ecuador. The project was implemented in the Provinces of Napo, Orellana and Sucumbíos, in a partnership between indigenous organizations, provincial health directorates, NGOs, municipalities, provincial councils and other institutional actors and organizations.

The project aimed at strengthening the capacity of community organizations and municipalities to manage health services and development initiatives. Its objectives included:

- To implement an intercultural community health care model

- To set up a comprehensive information system

- To consolidate the operation of the health network

- To support the development of a national health policy

- To contribute to improve the population's health status through community empowerment in finding solutions for health problems with an intercultural approach.

The community health project has been implemented in several geographical areas. The experience included in this document concerns actions undertaken in Canton Loreto.

Country	Ecuador
National context	<ul style="list-style-type: none"> • Inhabitants: 12,156,608 • Regions: Coast, Highlands, Amazon and Galapagos Islands. <p>POPULATION</p> <ul style="list-style-type: none"> • Indigenous: 830,418 • African descendants: 604,009 • Mestizo: 944,890 • White: 1,271,051 • Others: 39,240
Current constitutional principles	<ul style="list-style-type: none"> • Arts. 4, 44, 84 • Indigenous peoples mandates
Legal framework & Competence of the Health Sector	<ul style="list-style-type: none"> • 1999. Creation of the National Directorate for Indigenous Peoples Health (DNSPI). • 2002. Budgetary and staff reallocation to enable services delivery in 18 Provinces around the country. • 2004. Development of strategic components: Corporate and Institutional Development, Intercultural Health Models and Ancestral and Traditional Medicine Subsystems.



Type of experience	<ul style="list-style-type: none"> • Local.
Summarized description of the experience	<p>In 1987, the Federation of Organizations of the Kichwa People of Napo (FONAKIN) started a health programme in coordination with the Provincial Health Directorate of Napo. There was initial technical and financial support from the Swiss Red Cross and from the International Network of Health Organizations (RÍOS) at a later stage.</p> <p>Initial work was undertaken with communities on the Napo River banks as a response to that year's earthquake and in order to improve weak health services in the area. After several years of sustained intervention, the experience was replicated in Loreto, where several communities affiliated to the FONAKIN were located and lacked health services.</p> <p>The Loreto Health Network was created in 2001, in the Province of Orellana and health coverage was extended to include all the communities in the canton (nearly 80). New institutions and organizations, such as the Municipality of Loreto and the Health Services Modernization programme (MODERSA), joined the process. The aim of the network was to materialize the constitutional principles of universal, equitable and quality care through the implementation of community-based health actions.</p> <p>Furthermore, the project's approach and strategy are consistent with the structural reform of the Ecuadorian health system. Current laws call for the need to develop participatory health plans to be implemented by health services according to the guidelines of Cantonal Councils.</p>
Final objective of the experience	<ul style="list-style-type: none"> • To contribute to improve the population's health status through community empowerment in finding solutions for health problems in a way that would ensure quality, warmth, efficiency, equity and integrity, with due respect for <i>cultural diversity</i>.
Facilitating factors	<p>The methodological basis for this experience were:</p> <ul style="list-style-type: none"> • Institutional and intersectoral coordination • Organizational consolidation • Strengthening of government health services • Human resources training at local level • Health staff training and heightened awareness • Intercultural approach to health <p>Intercultural focus understood as:</p> <ul style="list-style-type: none"> • Respect for and knowledge of the Kichwa people health culture • Incorporation of the intercultural dimension in public health programmes, • Incorporation of indigenous medicine practitioners to the health network actions • Adaptation of intervention strategies to local conditions and culture • Cultural research and systematic information-gathering process

Obstructing factors	<ul style="list-style-type: none"> • High turnover rates among health staff • Initial lack of legal framework to support the process ¹².
Recommendations /Lessons learned	<ul style="list-style-type: none"> • Work cannot be achieved in isolation from the Government • In the coordination with government authorities it is important to work with all institutional bodies within the MOH, including operational, executive and management staff. • Intercultural approach must be viewed as a process • Strategies and tools must be simple • Leadership of indigenous organization • Development of the Cantonal Health Council • When working with government bodies, a good knowledge of the legal framework and public administration's regulations is required • There is the need for on-going documented registries in order to preserve information on lessons learned, mistakes and progress during the experience.
Other contributions	<ul style="list-style-type: none"> • Strategies aimed at ensuring the social, technical, financial and managerial sustainability of the process were implemented. • The experience has served as a reference model for the creation of intercultural health care models in regions with large presence of indigenous populations.

11. This experience has been systematized in the document "*Red de Salud de Loreto*", FONAKIN /RÍOS, 2005.

12. The current legal framework proposed by the Ministry of Health supports the tenants of the Community Health Project for the Northern Amazon Region in Ecuador.



- **MEXICO**

The *Oportunidades* (*opportunities*) Programme, launched under the *Contigo* (*with your help*) Initiative, is a comprehensive undertaking that encompasses interventions regarding food, health and education for vulnerable groups living in extreme poverty, indigenous peoples, among others. In indigenous health areas, the Programme has delivered basic health services packages and nutrition supplements for children under five years of age and pregnant or breast-feeding women. A 100 % coverage in immunization

and health surveillance actions is assured through the implementation of a national health booklet, among other actions.

Acknowledged key factors for success include: focussed resource management, incentives and actions designed on the basis of sound information and shared responsibility, assured inter-institutional coordination and operational efficiency, no interference (manipulation) allowed in programme matters, dissociation from political disputes and electoral conjunctures.

Country	Mexico
National context	<ul style="list-style-type: none"> • Though still high, mortality rates have dropped in almost 94 % in the last 110 years. Current rates are of 27 deaths per 1,000 viable births. In certain regions this rate rises to 79 deaths per 1,000 viable births in rural areas and 29 deaths per 1,000 viable births in urban areas. In indigenous areas percentages reach up to 123 deaths per 1,000 viable births.
Current constitutional principles	<ul style="list-style-type: none"> • The Constitution recognizes and guarantees the right of indigenous peoples and communities to self-determination and, consequently, to autonomy in order to enjoy effective access to health services. This is assured by an enlarged coverage of the national health system and the optimum use of traditional medicine. • Article 2. The Mexican nation is composed of multiple cultures and originally sustained by indigenous peoples. • Law 21/05/2003. Law on the National Commission for the Development of Indigenous Peoples. • Internal Regulations of the Health Secretariat. Art. 25, Section VII. Proposes the design and development of new health care models consistent with the needs and cultural characteristics of the population. • Section XVII. Promote actions for intercultural training and awareness of staff working for the national health system.

<p>Legal framework & Competence of the Health Sector</p>	<p>Indigenous Peoples Health Insurance particularly focused on indigenous peoples health needs (2004).</p> <p>Traditional medicine and intercultural focussed projects in health services.</p> <p>Draft proposal for an Indigenous Peoples Health Care Policy.</p> <p>Intercultural training process for staff attending Medicine and Nursing Schools.</p>
<p>Type of experience</p>	<p>National.</p>
<p>Summarized description of the experience</p>	<ul style="list-style-type: none"> • <i>Oportunidades</i> is a comprehensive programme that encompasses interventions regarding food, health and education for vulnerable groups living in extreme poverty. It is part of the capacity-building component of the <i>Contigo</i> Strategy. • The Programme provides focussed support for families living in extreme poverty and intends to break the vicious circle of poverty legacy from one generation to the other. For indigenous peoples this constitutes an equal opportunities mechanism to gain access to health and education services. • The system has one community participation committee per 100 families, composed of delegate members from the education, health and nutrition sectors. • Monitoring: there are 500 thousand committees around the country. • <i>Oportunidades</i> has resulted in a 49% increase in nutrition consultations for under five year olds in rural areas during the 1997-2002 period and a 19% increase in consultations for pregnant women during the same period.
<p>Final objective of the experience</p>	<p>To enlarge access to and improve the quality of health care services in poor areas around throughout the country.</p>
<p>Facilitating factors</p>	<ul style="list-style-type: none"> • Focussed resource management. • Incentives and actions designed on the basis of sound information and shared responsibility • Assured inter-institutional coordination and operational efficiency, applying the same rules for everyone = a single vision. • Compliance with joint responsibilities. • From the inception, establish the need for an independent impact assessment. • No interference (manipulation) allowed in programme matters, dissociation from political disputes and electoral conjunctures.



- **PANAMA**

The experience from Panama concerns the use of renewable solar energy panels to provide energy supply in places lacking this service. The initiative will enable the optimization of health services, for instance,

by incorporating cold chain potential. The Project includes a health training component for health professionals, as well as strengthened cooperation with empirical midwives and social participation through the creation of 100 committees.

Country	Panama
National context	<ul style="list-style-type: none"> • The Republic is administratively divided in 9 provinces, 75 districts or municipalities; there are 5 indigenous shires and 620 boroughs. 10% of the 2,8 million inhabitants are indigenous people.
Current constitutional principles /national laws	<ul style="list-style-type: none"> • Law No. 16 of February 19, 1953 created the Kuna Yala indigenous shire • Law No. 22 of November 8, 1983 created Emberá Wounnan indigenous shire. • Law No. 24 d of January 12, 1996 created the Madugandi indigenous shire. • Law No. 10 of March 7, 1997 created the Ngobe-Buglé indigenous shire. • En 1999, the third Goal of the National Social Agenda was to establish a policy with and for indigenous peoples.
Legal framework & Competence of the Health Sector	<ul style="list-style-type: none"> • Ministerial Resolution of August 25, 1999 creates Traditional Medicine Unit within the Ministry of Health. • Executive Decree No. 117, of May 9, 2003 creates the National Commission of Traditional Indigenous Medicine and the Technical Secretariat.
Summarized description of the experience	<ul style="list-style-type: none"> • The SOLEDUSA Project is based on the incorporation of new power generation technologies through the use of solar panels. • Under the health component, it is expected to train 200 health professional, including i.a. physicians, nurses and support health staff, in issues related to indigenous peoples' health. • Promote healthy lifestyles among selected project communities and enhance disease prevention through a network of 300 volunteer health promoters who would receive training on primary health care issues and health promotion techniques. • Cooperation with empirical midwives will be strengthened; it is estimated that 470 community members that perform this functions will be trained. • Closer interaction with 200 traditional practitioners will be facilitated by training them on the use of the basic medical procedures manual. • Social participation will be strengthened with the creation of 100 health committees.
Final objective of the experience	<ul style="list-style-type: none"> • The Project is aimed at improving the living conditions of indigenous communities and is particularly geared towards the health and education sectors associated to the schools located in the Province of Veraguas and in the Ngöbe Buglé indigenous shire.

• **VENEZUELA**

The experience presented concerned the Yanomami Health Plan. This project included capacity-building, significant investments in infrastructure and equipment as well as the provision of medical supplies and others. The project enabled the recovery and expansion of health services, quality improvement in the Health District operational functions through the creation of a maintenance

unit and a comprehensive epidemiological information system and local health staff and non-indigenous professionals training (mainly physicians, nurses, dentists and lab technicians).

The experience included the creation of an Intercultural Lodge to provide accommodation for indigenous patients relatives.

Country	Venezuela
National context	<ul style="list-style-type: none"> • Indigenous communities: 1,889 • Indigenous communities population: 183,343 • Indigenous population in the country: 533,691
Current constitutional principles	<ul style="list-style-type: none"> • The preamble of the Constitution of the Bolivarian Republic of Venezuela establishes a democratic, participative, protagonist, multiethnic and multicultural society. • The State shall recognize the existence of indigenous peoples and communities, their social, political and economic organization, their cultures, customs and traditions, their languages, their habitat and their original right over the lands they ancestrally and traditionally occupy, all of which are required to develop and ensure their lifestyles.
Legal framework & Competence of the Health Sector	<ul style="list-style-type: none"> • Health policies and programmes should adequately value each people’s view of the world and traditional medicine practices and shall favour their inclusion in health systems, particularly in the states with indigenous population. By the same token, the use of indigenous languages in health services shall be promoted by the presence of staff and interpreters who can facilitate communication. National Public Health institutions shall adapt their operations to indigenous traditional organizations and institutions and shall promote adequate training of health staff to provide services for indigenous peoples and communities. • Indigenous peoples are entitled to use their traditional medicines and therapeutic practices in the process aimed at preserving and restoring their health. This right includes the protection of plants, animals and minerals used for such purpose. This shall not undermine their right to enjoy access, with no discrimination, to all health institutions, facilities, services and programmes. • The State shall assure the conservation and regulation of indigenous traditional medicine and it shall regulate research initiatives in this field. From an intercultural vision, the contribution of indigenous traditional medicine to the strengthening of comprehensive health care for all shall be enhanced.



Type of experience	<ul style="list-style-type: none"> • National.
Summarized description of the experience	<ul style="list-style-type: none"> • Several actions have been taken in different areas such as human resources training at different level, investments in infrastructure, equipment and medical supplies, etc. • Yanomami Health Plan: Recovery and expansion of health services for the Yanomami people. • Operational improvement in the Health District (creation of a maintenance unit and of a comprehensive epidemiological information system). • Training provided to health staff and non-indigenous practitioners (mainly physicians, nurses, dentists and lab technician). Creation of the Intercultural Lodge where accommodation and health services are provided for indigenous patients' relatives of friends who accompany them.

These experiences are quite diverse and they significantly contribute to the main issue addressed in this document. The cases of complex networks of services that reach indigenous communities in large countries such as Brazil, Mexico or Venezuela, for instance, should be highlighted. The logistic organization, infrastructure, equipment, service management, as well as the decided promotion of community participation in planning, implementation and management accountability are some of the aspects worth noting in these experiences. Ecuador's contribution should also be mentioned, with the participation of indigenous organizations in the planning, implementation, financing and assessment phases of the experience. Indigenous organizations involvement has given a new momentum to the process and has invited local and national government authorities and other stakeholders involved in the health sector to join forces in order to optimize processes and obtain better results.

The experiences reviewed coincide in stressing the importance of respect for and acceptance of indigenous peoples' perspectives and knowledge as key elements for the adequate incorporation of and intercultural approach to health services delivery. Conventional medicine is currently run by professionals trained in Western medicine who, therefore, tend to look at things solely from the biomedical perspective. Despite certain progress in this sense, the line for a patient's referral to conventional medicine after receiving care under traditional medicine patterns remains ambiguous. It would be difficult to establish strict referral criteria in these cases, particularly since a closer interaction between conventional and traditional medicine is recent and still incipient.

Infrastructure, equipment, supplies, together with organized logistics and transportation systems are vital resources in any activity and become particularly vital in health services. This is specially

the case if those resources have to be provided through diligent, efficient and transparent management systems open to public scrutiny.

Key elements for success in the implementation of these programmes are linked to financial sustainability, freedom of action dissociated from political powers and clearly established accountability mechanisms.

A common element to all the experiences described is the involvement of different population groups in the planning, implementation and assessment phases of any project that aims at the successful integration of institutional and community visions in health services delivery. Integrated community participation in services delivery is paramount since the beneficiaries of services are best situated to appreciate the flaws or virtues of the system and can express unbiased opinions.

District authorities commitment to participate in health services delivery, within the limits of their resources and operational capacity, is yet another facilitating factor in the promotion of initiatives aimed at improving health services, particularly in areas with indigenous population. Local administrative territorial units are usually the closest and more permanent level of contact with citizens, taking further into account that growing urbanization is one of the most significant phenomena in recent years in the Region.

The incorporation of indigenous staff in intercultural health services and general capacity-building concerning knowledge and acceptance of ancestral medicine practices to improve health practitioners understanding of indigenous peoples' wisdom and their life dynamics, are quantifiable advances in this process, especially since training tends to be imparted in a two-way system. Thus, conventional medicine health professional are trained in ancestral medicine practices while local capacity-building is strengthened by promoting indigenous peoples identity and curative resources.

Currently there are several experiences that include the involvement of midwives, healers, bone-setters and other traditional medicine practitioners who, above all, are accepted and respected. Several of them provide services in formal health facilities.

Inter-institutional coordination is another aspect that contributes to efficiently address the organization of comprehensive health services. It must be recalled that, in its larger sense, health encompasses and integrates actions which might be administratively allocated to other sectors but that remain intrinsically linked to the concept of health. Some examples might be the efficient delivery of important services such as drinking water supply, sewage, sanitation, latrines or solid waste management; they must all help to ensure a safe and health habitat to improve the health status in human settlements. If



health services limit their interventions to immunization, vector spraying campaigns and other similar actions, they will be fostering curative and not preventive medicine, with no vital incidence on the health conditions of the population groups they target.

Among the most frequently mentioned factors that could obstruct the implementation of intercultural health systems are political interference, cronyism, mistrust and lack of credibility in authorities and public officials.

Another difficulty is posed by inconsistencies between traditional indigenous territories borders and the political and administrative units of States, since the latter are responsible for the management of economic resources allocated by the central Government. Additional obstacles mentioned are linked to the lack of specific government policies on this issue and insufficient human resources for health services management and delivery.

Other obstacles might stem from indigenous populations themselves, such as misconstrued roles played by indigenous organizations who consider themselves not only representatives but also inherent health services providers. This generates conflict both within and between such organizations.

Proposed recommendations underscore the importance of indigenous peoples'

involvement both at the level of Ministries of Health –in public policies management, and in the joint management of health services. Other recommendations encourage the adoption of a holistic approach to solve these problems, the development of accreditation processes for traditional medicine practitioners, the implementation of multisectoral and inter-institutional actions, the consolidation specific national legal frameworks and the definition of parameters to assess users' satisfaction.





ELEMENTS
WORTH
CONSIDERING
IN AN
INTERCULTURAL
LICENSING AND
ACCREDITATION
SYSTEM



A licensing and accreditation system for intercultural health services should encompass both the technical quality of the service and the perceived quality by the users, together with the health team, considered as a cohesive group of individuals who act in the pursuit of a common goal. Due account must be taken of both indigenous and non-indigenous staff members, any geographical, economic and financial barriers that could jeopardize efficient quality in services delivery and the institutional organization of health services.

Licensing systems should also pay attention to referral and counter-referral mechanisms between different levels of complexity in order to place patients under apt and efficient care, as well as to the design of referral and counter-referral mechanisms between conventional and indigenous health systems.

When conceived under a certified health care model, these elements could help improve access to health services and their quality delivery for excluded sectors of the population.

For technical quality improvement, it is important to have a common set of technical quality standards applicable throughout the health system, including standards that ensure intercultural health care. A supplementary set of quality standards should be commonly agreed, in due time, for indigenous traditional health care, particularly regarding safety and effectiveness.

In order to improve the levels of perceived quality in services delivered, these must be person-centred and always take into account users' needs and expectations, including the patient's right to decide from the outset the type of care he or she wants to receive, as well as the right to be informed about the clinical process in understandable language and formats.

If the case so requires or calls for, and in compliance with existing laws and regulations, consent forms will be provided for signature by the health care unit for high-risk procedures, research projects or others, ensuring that users have properly understood their contents.

In any case, quality standards must be consistent with the view of the world of concerned indigenous populations.

Health teams must be created applying interdisciplinary criteria. Depending on the level of complexity of the service, health team members must be competent and have expertise in communicating with indigenous people living in the area and must be familiar with and show respect for traditional health practices.

The problem of geographical barriers must be addressed with the participation of local authorities and communities. Among other measures, this strategy must include adequate budgetary allocations for the renewal or procurement of means of transport, environmentally-sound road improvement, community education and planning and

implementation of drills concerning transport and evacuation of patients.

The use of available economic resources under efficient, transparent and accountability mechanisms will contribute to improve the quality of health services and their accreditation to meet the population needs. In this sense, central governments play a crucial role in the allocation of sufficient resources in a sustained and equitable pattern, in order to ensure the sustainability of health services. Governments should also develop and implement thoroughly financed medium and long-term projects in order to enlarge the coverage of health services.

Health services organizational structures should undoubtedly include an institutional system to enable the real participation of users in services planning and design. This is particularly relevant when health services areas of influence include indigenous settlements. Health authorities should prioritize the professional stability of health staff specialized in health care services for indigenous populations and the development of information systems that include ethnicity and ethnic relevance among their variables.

In the design of referral and counter-referral mechanisms between conventional and traditional health systems, allowance must be made for a joint and coordinated collaboration between conventional and traditional practitioners, always seeking for excellence in the delivery of health services. This kind of service will enable a coordinated interaction between indigenous therapists

and conventional medicine professionals within health teams, as well as timely, commonly-agreed referrals.

The following matrix summarizes the elements that should be taken into account in the development of intercultural licensing and accreditation systems:



Category	Facilitating Factors	Obstacles	Observations
Technical Quality	<ul style="list-style-type: none"> • Common set of technical quality standards, applicable throughout the health system, including standards to ensure intercultural health care. • A supplementary set of standards for traditional health care should be developed in due time. 	<ul style="list-style-type: none"> • Charlatans. • Rejection of conventional medicine by traditional medicine and vice versa. • Medical services autonomy. • Differences in health status appraisal between conventional and traditional medicines. • Conventional medicine has not assured yet sufficient safety and quality standards; practices are not comprehensive. 	<ul style="list-style-type: none"> • Awareness must be heightened regarding the need for standards regulating traditional practices, in particular regarding safety. • Participation of indigenous peoples through government licensing and accreditation systems • Establish self-developed licensing and accreditation mechanisms. • Further clarification of the concept of quality in both systems. Are they similar? • Include variables of ethnicity and ethnic relevance in the national information system.
Perceived Quality	<ul style="list-style-type: none"> • Health care must be user-centred and, therefore, must take into account patients needs and expectations. • Staff must have knowledge about the type of population that seek care at the health unit. • A methodology must be used to assess the needs and expectations: surveys, focal groups, quantitative and qualitative research. • Users right to choose the kind of health care they wish to receive. • Right to be informed and to take decisions regarding your own clinical process; right to be informed in comprehensible language and formats. • Use documents on prior informed consent for high-risk procedures and research projects. • Right to receive care in your native language. 	<ul style="list-style-type: none"> • Ethnocentric bias in health care. • Limited health services openness to users or community participation. • Limited users or community participation in health care management • Cultural barriers in explanations and understanding of clinical procedures. • Lack of information material in native languages. 	<ul style="list-style-type: none"> • Develop perceived quality standards from the community's perspective. • Develop standards consistent with indigenous peoples' view of the world. • Develop information material, together with the community in formats and with terminology its members can understand. • Prior informed consent documents must be developed with community participation.

Category	Facilitating Factors	Obstacles	Observations
Health Team	<ul style="list-style-type: none"> • Creation of multidisciplinary teams at all levels. • Interaction between disciplines. • Staff continuity in duties. • Professional stability. • Staff trained and equipped with skills in dealing with concepts related to an intercultural approach. • Local health staff aware of local realities. 	<ul style="list-style-type: none"> • Indigenous therapists fear to be relegated. • Insufficient staff • Staff with no training or limited knowledge regarding PHC implementation. • Human resources with no apparent affinity with community health care. 	<ul style="list-style-type: none"> • Provide incentives for health promoters who reach remote locations. • Eliminate discriminative and isolation processes. • Implement telemedicine centres to keep health staff updated with new developments in health care.
Indigenous Personnel	<ul style="list-style-type: none"> • Skills for negotiation and intercultural communication. • Sense of belonging to their community. • Recruitment of staff whose training is consistent with their peoples' traditions. • Acceptance of the community and indigenous therapists. • Knowledge of both conventional and traditional medicine. • Team with indigenous therapists with their own field of action and responsibilities. • On-going training 	<ul style="list-style-type: none"> • Indigenous staff members trained in conventional medicine who do not return to their communities. • Low number of people who meet the described criteria vis-a-vis the demand for such personnel. 	<ul style="list-style-type: none"> • Processes must be designed in such a way as to prevent therapist from deserting community life. • Generate commitments to preserve ties with the community during and after their training. • Generate spaces to facilitate their incorporation to their community or organization health processes from the very beginning. • Establish a network of indigenous health professionals.
Non-indigenous Personnel	<ul style="list-style-type: none"> • Communication and negotiation skills. • Traditional medicine knowledge. • Training and specialization in community health. • Adequate training programmes with intercultural contents. • On-going training on intercultural health care. 	<ul style="list-style-type: none"> • Lack of commitment and community vision in their professional performance. • High turnover rates among already trained staff. • Lack of knowledge regarding the concepts of health & disease applied in traditional health systems. 	<ul style="list-style-type: none"> • Information on traditional medicine. • Create awareness among new staff members who join the service. • Provide incentives for goals achievement.



Category	Facilitating Factors	Obstacles	Observations
Geo-graphical Barriers	<ul style="list-style-type: none"> • Communication and transport means adapted to local realities and with specific budget. • Telemedicine • Local authorities' intervention to overcome geographical barriers. • Decentralization and less concentration of powers. • Adequate assignment of health staff. • Alliances with professional and trade associations. • Community participation in planning and decision-making. • Services adapted to local realities: mobile health units, shelters, intercultural health services. 	<ul style="list-style-type: none"> • Indigenous communities are often located in remote geographical areas where operational units have almost no capacity to solve health problems. • Reduced outreach work. • Limited community participation in planning. • Small populations unknown to health services. 	<ul style="list-style-type: none"> • Improvement of communications and transport infrastructure in-keeping with local sustainable development. • Strategic plans development with the involvement of all stakeholders, particularly district authorities. • Adapt health services to local realities: opening hours, shelters, mobile health units.
Economic and Financial Barriers	<ul style="list-style-type: none"> • Efficient use of available resources. • Models for social security with solidarity. • Fixed basic budgetary allocation for government investment in health. • Corporate social responsibility. • Socioeconomic survey of the population. • Adequate and assured budgets for long term project completion. • Clinical and evidence-based management. • Local governments involvement in financing activities. • Transparent participation of external cooperation agencies in financing. • Community participation in resource management. 	<ul style="list-style-type: none"> • Indigenous populations poverty and vulnerability. • Non- equitable distribution of resources. • Overlapping activities undertaken by public and private bodies, resulting in waste of resources. • Economic resources allocation must be based on different parameters and not only on the basis of demographic data. • Deficit. • The financial system does not consider inherent community criteria such as payment in kind. 	<ul style="list-style-type: none"> • Depending on the country, prioritize coverage for the poorest and most vulnerable groups of the population with equity criteria. • Enlarge coverage to optimum levels (ideally 100%). • Develop strategies for technical, financial, social and management sustainability. • Diversify financial sources. • Establish transparent financial management mechanisms. • Involve the community in planning, implementation, monitoring and activities assessment processes. • Accountability

Category	Facilitating Factors	Obstacles	Observations
<p>Organi- zation of the Health Service</p>	<ul style="list-style-type: none"> • Humane services delivery. • Intersctoral and inter-institutional coordination in health, education, social policies and justice. • Incorporation of programmes and processes that have included an intercultural approach. • Systematic community participation in planning, design and management. • Joint participatory and community-oriented management. • Adaptation of services to cultural patterns and local demands. • Internal reform processes in the health sector aimed at the reorganization of health services. • Relevance of primary health care. • Renewed principles of primary health care. 	<ul style="list-style-type: none"> • Limited native languages skills among health staff. • Lack of information and feedback on processes. • Limited development of clinical records of large spectrum that include anthropological, cultural and medical contexts. • Limited coordination between the academia, ministries, services and communities. 	<ul style="list-style-type: none"> • Organization of health units on the basis of their capacity to treat cases and their geographical coverage. • Identification of a geographic and demographic unit as a basis for health care. • Redistribution and recruitment of additional human resources with specific allocation of operational geographical areas. • Creation of local networks and micro networks (local health systems) • Strategic guidance and planning (strategic plans for networks and operational plans for micro networks) • Enable users' real participation in services planning and design. • Promote professional career development for staff specialized in health services for indigenous populations. • Develop information and monitoring systems with the incorporation of additional necessary variables, such as ethnicity. • Consider users mobility. • Agreements between countries regarding health services delivery for specific groups of the population (nomads, refugees, migrant workers, seasonal workers, non-contacted peoples) • Coordination between health systems from countries with indigenous populations. • Partnership between the academia, ministries, services and communities.



Refer- ral and Counter- referral System between different levels of complex- ity	<ul style="list-style-type: none"> • Establishing the notion of “continuity in health care”. • Incorporation of support services, shelters for patients and their relatives. • Management agreements between local stakeholders, in particular with municipal authorities. • Community involvement in demanding respect for their rights. 	<ul style="list-style-type: none"> • Limited follow-up and monitoring of the referral and counter-referral system. • Lack of entry point to access the system. • Weak commitment or lack of knowledge regarding the implementation of the referral and counter-referral system. 	<ul style="list-style-type: none"> • Ensure transfer /transport of indigenous patients referred to other levels of required health care. • Create a national health card –to be delivered by local health teams, to follow the patient’s progress throughout the system. • Single resource management at regional level. • Establish guidelines or protocols for local health care delivery.
Refer- ral and Counter- referral System between Conven- tional and In- digenous Health Systems	<ul style="list-style-type: none"> • The service enables interaction between indigenous therapists and conventional medicine practitioners within health teams. • Ethics in traditional medicine practices. • Acceptance of the diagnosis established by traditional therapists. • Timely referrals and counter-referrals at community level. 	<ul style="list-style-type: none"> • Lack of protocols and intercultural regulatory tools as well as lack of intercultural academic training. • Lack or limited application of the conventional referral and counter-referral system. • Limited knowledge of or respect for traditional wisdom. • Weak credibility of conventional practices among traditional therapists and of traditional practices among conventional medicine practitioners. 	<ul style="list-style-type: none"> • Implement means of communication for communities located in remote/inaccessible areas. • Within the system, joint and co-ordinated work should be possible between practitioners following either approach to health care.
Cultural Barriers	<ul style="list-style-type: none"> • Adequate and accessible services. • Local language skills of health workers. • Holistic vision of health staff. • Community participation in planning, implementation and assessment of activities. • Leaders responsible for motivating health staff and promoting openness regarding outreach work. 	<ul style="list-style-type: none"> • Cultural barriers used as an excuse to hide inefficiencies. • Lack of language knowledge. • Lack of information regarding intercultural approaches to health care. 	<ul style="list-style-type: none"> • Committed and responsible staff is a must. • Intercultural awareness. • Holistic management of the health-disease process.

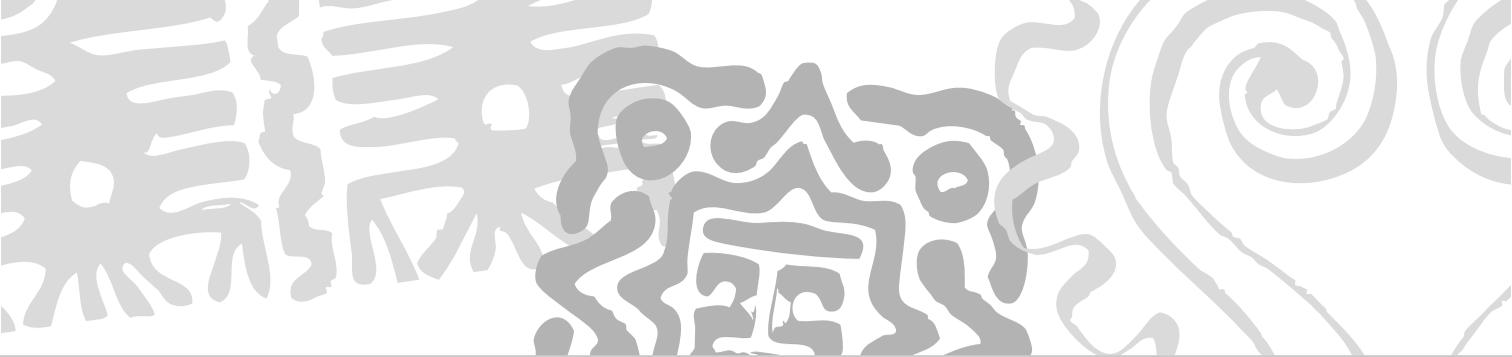


CON- CLU- SIONS

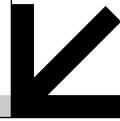


Conclusions need to be set in the context of the realities of each country. The following conclusions have been identified:

- Indigenous peoples in the Americas pose the need for the recognition of ancestral wisdom on equal footing with Western knowledge.
- Theoretical knowledge developed on intercultural approach should materialize in real health practices.
- There is a need to increase the number of indigenous health professionals to work at community level.
- Decision-making processes should be decentralized at local and district level.
- There is resistance to change among certain elements of the health system.
- There are internal divisions among indigenous peoples.
- Many indigenous communities face the problem of cultural transfer that can be reflected in a form of “ethnic shame”. Young indigenous people, in particular, resent or take amiss their origin.
- Indigenous peoples’ representation systems are extremely versatile and this can have an adverse impact on the value afforded to their leaders and their representative role.
- The loss of cultural identity, compounded by economic reasons, has endangered the preservation of indigenous peoples’ traditions. Development and environmental degradation have reduced the production of medicinal plants and this, in turn, has undermined traditional medicine practices.
- Young people suffer from family disaggregation, lack of employment at community level and they do not feel inclined to preserve traditions.
- There are internal divisions among community leaders and traditional medicine practitioners.
- Indigenous patients and their relatives are discriminated against and suffer from exclusion, particularly at hospital level.
- Political problems and the association of initiatives with a specific political option could generate rejection from certain groups of the population.
- Information systems do not include the ethnicity variable with ensuing difficulties for planning processes. Current statistics are no very reliable and there is an under registration of morbidity and mortality data.
- Western culture does not accept traditional medicine as a valid option.



RECOM- MENDA- TIONS



- Due recognition must be given to a holistic approach to health and integration must respect the spiritual dimension.
- The vulnerability of indigenous peoples and their specific conditions of access to health services must be acknowledged.
- Official health systems must acknowledge the existence of other health systems, as operational and valid as themselves, and must develop mechanisms for interaction. To this end, traditional medicine should be promoted as an element of indigenous knowledge.
- An intercultural approach definition must include the need to incorporate training for currently employed staff.
- PAHO should create working groups to define the scope of an intercultural approach to health and of the interrelation between health systems and operational mechanisms. Experts and indigenous organizations from different countries could join these groups.
- Official health systems should provide for mechanisms aimed at the empowerment of indigenous peoples and grass-roots organizations and their consolidation.
- Spaces for participation to facilitate decision-making on health issues should be created, with two-way communication and information mechanisms for governments and indigenous peoples.
- Quality standards should be set together with indigenous peoples.
- Health systems should not be divided into a specific system for indigenous peoples and another for the rest of the population.
- Political leaders must keep in close touch with their constituency since communities are gaining increased power.
- Health practitioners must have a good understanding of the characteristics of the indigenous peoples with whom they shall be working. Even greetings are important aspects.
- Incorporate elements of traditional medicine in intercultural bilingual education.
- Prevention of specific risk factors concerning indigenous population should be implemented at first level of health care, in coordination with other levels of care where certain pathologies are detected.
- The post of intercultural facilitators should be created at hospital level. An example is the incorporation of the ethnic group variable in the registry system of the University Hospital of Caracas. (This requires especial software).
- Develop an accreditation system for intercultural services.
- Promote the participation of indigenous communities.

- Consider accommodation at first level of health care. Sometimes referral to hospitals is not possible or the patient refuses to be referred to another health facility.
- There is the need for some form of accreditation for traditional medicine practitioners. Though Western standards could be adapted, specific standards must be developed. The community will validate such accreditation through their recognition.
- Economic and political support for these initiatives is required.
- Ministerial agreement should exist to accredit certain health agents.







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AN- NEX- ES

**HEALTH PROGRAMME OF THE INDIGENOUS PEOPLES OF THE AMERICAS
PAN AMERICAN HEALTH ORGANIZATION
PRIMARY HEALTH CARE AND
INTERCULTURAL FOCUS**

Quality in Health Care Services
for Indigenous Peoples
Workshop for Exchange of Experiences

Sponsored by:

Health Programme of the Indigenous Peoples
of the Americas, PAHO

Language:

Spanish

Dates:

7-9 November, 2005

Place:

Quito, Ecuador

Duration:

3 days

Participating countries:

Bolivia, Brazil, Colombia, Ecuador, Guatemala,
Mexico, Nicaragua, Panama, Venezuela

Purpose:

Identify aspects that should be taken into account in the development of a licensing and accreditation system based on primary health care principles and an intercultural approach to health.

Objectives:

- To know best practices in health care services for indigenous peoples through selected experiences.

- To examine the characteristics of practices, services and providers in relation to standards of technical and perceived quality in areas with indigenous population, including the incorporation of indigenous traditional medicine and therapists.

- To identify indicators for the assessment of i.a. users' satisfaction, improvement in access, incorporation of indigenous perspectives, therapies and medicines in health care protocols, etc.

- To recommend strategies and steps for the development of a licensing and accreditation system for health services delivery with and intercultural focus and in-keeping with primary health care principles.

Expected Results

- To disseminate and systematize information on quality health services delivery in areas with indigenous population, with emphasis on the incorporation of indigenous perspectives, therapies and medicines in primary health care.

- To develop a contents proposal for a licensing and accreditation system for health services delivery with intercultural focus and in-keeping with primary health care principles.

- To identify indicators that would enable the assessment of technical quality and quality as perceived by users, taking into account the specific characteristics of indigenous populations.

- To identify strategies and prepared an action plan for the development of a licensing and accreditation system for health services delivery with and intercultural focus and in-keeping with primary health care principles.

Criteria for the selection of experiences

1. At least five years experience in the delivery of culturally-appropriate and PHC-based health services in areas with indigenous population.
2. Coordination with indigenous organization in the areas where the experience is carried out. Indicate the names of the organizations and the type of collaborative activities implemented.
3. Indigenous staff involvement. Indicate their specific functions or roles.
4. Coordination with the Ministry of Health. Indicate the level of cooperation (national, local, etc). Indicate the type of collaborative activities carried out.
5. Coordination between programmes for the improvement of quality in health services for indigenous peoples and general programmes for the overall improvement of the national health system and primary health care in particular.
6. Coordination with academic institutions. Indicate the name of the academic institutions and the type of collaborative activities implemented.
7. Candidate institutions should send a 500 word summary of the work carried out,

emphasizing the features that qualify it as an experience in PHC-based health services delivery with intercultural focus. This document must be sent by August 26, 2005

8. The results of the selection of experiences will be communicated on September 5. Only one experience will be selected per country. PAHO Health Programme of Indigenous Peoples in the Americas will finance the participation of one person per experience. Attendance of additional participants sponsored by selected institutions our countries will be welcomed.

9. The person representing the experience will make a 20 minute presentation according to the provisions of the attached Guidelines.

Participants:

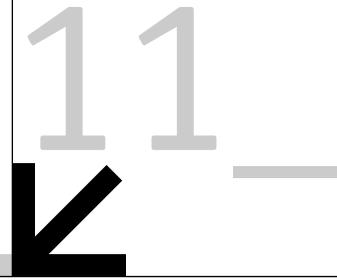
Ministries of Health
Indigenous Organizations
Academic Institutions
International Cooperation Agencies
NGOs

Number of participants:

15 persons

Methodology:

Presentations made according to the established guidelines, working groups (moderator and rapporteurs must be designated), plenary sessions (appointment of moderators and rapporteurs).



AGENDA

Workshop

Quality in Health Care Services for Indigenous Peoples

Day 1	<p>Welcome</p> <p>Indigenous Ritual Ceremony</p> <p>Opening Session I</p> <p>INTRODUCTION</p> <p>Participants Introduction – Expectations and concerns</p> <p>Review of the Workshop objectives and Agenda</p>	<p>PAHO</p> <p>Ministry of Health</p> <p>National Directorate for Indigenous Health</p> <p>Indigenous therapists</p> <p>Participants</p>
	<p>Session 1</p> <p>9:00 – 10:00:</p>	
10:00 – 10:30	BREAK	
<p>Session 2</p> <p>10:30 – 11:30</p>	<p>HEALTH OF INDIGENOUS PEOPLES: PRIMARY HEALTH CARE AND INTERCULTURAL FOCUS</p> <p>Health of Indigenous Peoples and Intercultural Focus</p> <p>Rocío Rojas MD, PAHO/WHO - Ecuador</p> <p>Principles of renewed primary health care</p> <p>Jorge Prospero MD, PAHO/WHO-Ecuador</p> <p>DISCUSSION/QUESTIONS</p> <p>Moderator: Ecuador</p> <p>Comments: Bolivia</p>	<p>PAHO/INDIGENOUS REPRESENTATIVES</p> <p>Plenary Session</p>
11:30 – 12:30	<p>CONCEPTUAL REVIEW:</p> <p>Juan Fernandez Martín, MD, PAHO/WHO-WDC</p> <p>Health, quality, access, licensing, accreditation</p> <p>DISCUSSION/QUESTIONS</p> <p>Moderator: Guatemala</p> <p>Comments: Brazil</p>	<p>PAHO/PARTICIPANTS</p>
12:30 – 2:00	LUNCH	
<p>2:00 – 3:00</p> <p>Working Groups</p>	<p>REVISION CONCEPTUAL: HEALTH, INTERCULTURAL FOCUS, QUALITY, ACCESS, LICENSING, ACCREDITATION, PRIMARY HEALTH CARE</p> <p>Challenges posed by the incorporation of indigenous vision</p> <p>RECOMMENDATIONS</p>	<p>Working Groups</p> <p>Moderators</p> <p>Rapporteurs</p>
3:00 – 3:30	BREAK	
3:30 – 4:00	Working Groups Reports	Rapporteurs
4:30 – 5:30	<p>HEALTH SERVICES DELIVERY IN AREAS INHABITED BY INDIGENOUS PEOPLES: Elements of the Licensing and Accreditation System, monitoring indicators and quality assessment of health services</p> <p>Jorge Prospero, MD, PAHO/WHO-Ecuador</p> <p>DISCUSSION/QUESTIONS</p> <p>Moderator: México</p> <p>Comments: Chile</p>	<p>PAHO/PARTICIPANTS</p> <p>Presentations</p>

<p>Day 2</p> <p>8:30 – 9:30</p> <p>Presentation of experiences 20 minutes each</p> <p>Bolivia Brazil Colombia</p>	<p>HEALTH SERVICES DELIVERY IN AREAS INHABITED BY INDIGENOUS PEOPLES</p> <p>Factors to be considered Progress and challenges</p> <p>Recommendations for the development of a licensing and accreditation system, monitoring indicators and quality assessment of health services in areas inhabited by indigenous populations Moderator: Panamá</p>	<p>PAHO/SELECTED EXPERIENCES/ PARTICIPANTS/ RAPPOREURS Presentations Matrix</p>
<p>9:30 – 10:00</p>	<p>Q & A</p>	
<p>10:00 – 10:30</p>	<p>BREAK</p>	
<p>10:30 – 11:30</p> <p>Presentation of experiences 20 minutes each</p> <p>Chile Ecuador Guatemala</p>	<p>HEALTH SERVICES DELIVERY IN AREAS INHABITED BY INDIGENOUS PEOPLES</p> <p>Factors to be considered Progress and challenges</p> <p>Recommendations for the development of a licensing and accreditation system, monitoring indicators and quality assessment of health services in areas inhabited by indigenous Moderator: Venezuela</p>	<p>PAHO/SELECTED EXPERIENCES/ PARTICIPANTS/ RAPPOREURS Presentations Matrix</p>
<p>11:30 – 12:00</p>	<p>Q & A</p>	
<p>12:00 – 1:30</p>	<p>LUNCH</p>	
<p>1:30 – 2:30</p> <p>Presentation of experiences 20 minutes each</p> <p>México Panamá Venezuela</p>	<p>HEALTH SERVICES DELIVERY IN AREAS INHABITED BY INDIGENOUS PEOPLES</p> <p>Factors to be considered Progress and challenges</p> <p>Recommendations for the development of a licensing and accreditation system, monitoring indicators and quality assessment of health services in areas inhabited by indigenous populations Moderator: Colombia</p>	<p>PAHO/SELECTED EXPERIENCES/ PARTICIPANTS/ RAPPOREURS Presentations Matrix</p>
<p>2:30 – 3:00</p>	<p>Q & A</p>	
<p>3:00 – 3:30</p>	<p>BREAK</p>	
<p>3:30 – 5:30</p>	<p>ROUNDTABLE ON INDIGENOUS KNOWLEDGE Health and health care from indigenous perspective Taita Franklin Columba Yachac Javier Perugachi Moderator: Ecuador</p>	<p>INDIGENOUS THERAPISTS</p>



<p>Day 3</p> <p>8:30 – 10:00</p> <p>Working Groups</p>	<p>ELEMENTS TO BE CONSIDERED IN A LICENSING SYSTEM WITH INTERCULTURAL FOCUS</p> <ul style="list-style-type: none"> Human resources/conventional and indigenous health systems Health facilities Monitoring indicators and quality assessment Future actions 	<p>PARTICIPANTS</p>
<p>10:00 – 10:30</p>	<p>BREAK</p>	
<p>10:30 – 12:30</p>	<p>ELEMENTS TO BE CONSIDERED IN A LICENSING AND ACCREDITATION SYSTEM WITH INTERCULTURAL FOCUS</p> <ul style="list-style-type: none"> Human resources Health facilities Monitoring indicators and quality assessment Future actions 	<p>PARTICIPANTS</p>
<p>12:30 – 2:00</p>	<p>LUNCH</p>	
<p>2:00 – 3:30</p>	<p>Working Groups Reports</p>	<p>RAPPORTEURS</p>
<p>3:30 – 4:00</p>	<p>BREAK</p>	
<p>4:00 – 5.00</p>	<p>CONCLUSIONS AND ACTION PLAN</p>	<p>PAHO/MOHs/ INDIGENOUS LEADERS</p>
<p>5:00 – 5:30</p>	<p>CLOSING RITUAL CEREMONY</p>	<p>INDIGENOUS ORGANIZATIONS</p>

GUIDELINES FOR PRESENTATIONS

A representative of each experience will make a 20 minute presentation with special emphasis on the following aspects:

1. Location of the project.
2. Indigenous peoples percentage.
3. Number of indigenous peoples (names).
4. First 10 causes for mortality and morbidity in general and per age group, gender and ethnicity.
5. Number of years of experience.
6. Facilitating and obstructing factors in the delivery of accessible and culturally appropriate health services.
7. Addressing geographical, economic, social, cultural and organizational barriers.
8. Monitoring indicators and assessment of technical quality and quality as perceived by the user.
9. Health team characteristics (number of indigenous and non indigenous physicians, nurses, dentists, sociologists, anthropologists and indigenous therapists).
10. Referral and counter-referral system between different levels of complexity within the health services network.
11. Referral and counter-referral system between the official or conventional health system and the indigenous health system.
12. Intersectoral and inter-institutional activities as well as activities carried out with indigenous organizations.
13. Recommendations for the establishment of a licensing and accreditation system for health services based on PHC principles and with intercultural focus.



Presentation of Experiences / Matrix for Rapporteurs

CATEGORY	POSITIVE FACTORS	OBSTACLES	OBSERVATIONS
1. Technical Quality			
2. Perceived Quality			
3. Health Team			
4. Indigenous Personnel			
5. Non-indigenous Personnel			
6. Geographical Barriers			

CATEGORY	POSITIVE FACTORS	OBSTACLES	OBSERVATIONS
7. Economic Barriers			
8. Financial Barriers			
9. Organizational Barriers			
10. Access Indicators			
11. Technical Quality Indicators			
12. Perceived Quality Indicators			



CATEGORY	POSITIVE FACTORS	OBSTACLES	OBSERVATIONS
13. Quality Monitoring and Assessment System			
14. Access Monitoring and Assessment System			
15. Health Staff Monitoring, Supervision and Assessment System			
16. Referral and counter-referral system between different levels of complexity			
17. Referral and counter-referral system between conventional and indigenous health systems			

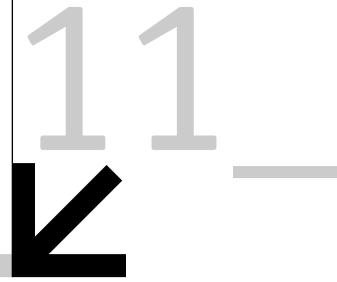


ORGANIZACIÓN PANAMERICANA DE LA SALUD
Oficina Sanitaria Panamericana, Oficina Regional de la
ORGANIZACIÓN MUNDIAL DE LA SALUD

**WORKSHOP ON QUALITY STANDARDS FOR THE DEVELOPMENT
OF INTERCULTURAL HEALTH MODELS IN AREAS INHABITED
BY INDIGENOUS PEOPLES**

Quito, Ecuador, June 5, 2007

8:00 - 8:30	Opening Session PAHO-MOH
8:30 - 9:00	Indigenous Ritual Ceremony
9:00 - 9:15	Workshop Objectives and Methodology Rocío Rojas, MD Regional Adviser Health of Indigenous Peoples PAHO/WHO
9:15 - 10:15	Strategic Guidelines in the Development of Intercultural Models in Ecuador. Lety Viteri, MD, Director Directorate for Indigenous Peoples Health Ministry of Public Health of Ecuador
10:15 - 10:30	Break
10:30 - 11:00	Incorporation of indigenous peoples perspective in the process towards the achievement of the Millennium Development Goals Luz María Vega, MD, Decentralized Health System, Cotacachi, Ecuador
11:00 - 11:30	Development of disaggregated information by ethnicity Miguel Machuca, MD, PAHO/WHO
11:30 - 12:00	Quality standards in intercultural health services delivery in areas inhabited by indigenous peoples Rocío Rojas, MD, PAHO/WHO, Rodrigo Cevallos, Eng, Consultant



12:00 - 12:30	Integrated Intercultural Health System Luz Marina Vega, MD, Municipality of Cotacachi
12:30 - 13:00	Traditional indigenous medicine and health services Miriam Conejo, Jambi Huasi, Otavalo
13:00 - 14:00	Lunch
14:00 - 14:30	Traditional, alternative and supplementary medicines in health services Area # 9, MOH, Guamaní.
14:30 - 15:00	Intercultural health services in remote and border areas Alfredo Amores, MD, Loreto
15:00 - 15:30	Human resources development with intercultural approach Luis Fernando Sarango, Universidad Amawtay Wasi
15:30 - 16:00	Break
16:00 - 17:00	Working Groups: Review of the proposal for licensing and accreditation of intercultural health services
17:00 - 17:30	Reports on Working Groups results
17:30 - 18:00	Closing Session

GLOSSARY

Indigenous population and indigenous peoples

Denominations used to identify these peoples have changed from one country to the other depending on their social and historical contexts, native languages, ascent, self - identification, geographical concentration and the territories they occupy. (PAHO, 1998)

Likewise, terms have been used in assigning names to indigenous populations. Examples include: indigenous population, indigenous peoples, original peoples, native communities, tribes, nations, native Americans in the United States, ethnic groups in Honduras, ethnic groups, first nations in Canada, nationalities in Ecuador, societies in Brazil and Amerindians 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 Guaymies.

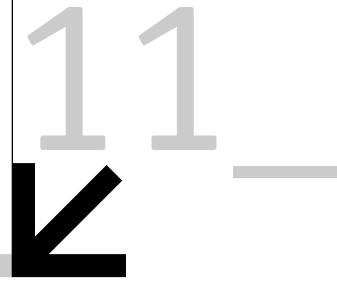
This text uses the term "people". The concept of "people" refers to the features characterizing a human group in territorial, historical, cultural and ethnic terms that confer a sense of identity to it (Stavenhagen 1992). In addition, ILO Convention No. 169 concerning Indigenous and Tribal Peoples in 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".

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.

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



wellbeing, which includes the spiritual dimension and the consideration of health determinants. For example, at a health workshop organized 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 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 fulfilment and peace.” When the indigenous leaders of the Salvadorian National Indigenous Coordinating Board (CCNIS, 2000) were asked what health was, 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 and promotes the self-determination of peoples.

Primary Health Care

In 1978, the Alma Ata Declaration defined Primary Health Care as 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 and at a cost that the community and country can

afford to maintain. It forms an integral part of both the country’s health system and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process (Renewing Primary Health Care in the Americas , PAHO, 2005).

Access

Different sectors contacted in a number of countries during technical cooperation missions (MOHs, academic institutions, indigenous peoples organizations, NGOs, PAHO/WHO Country Offices) have expressed concern regarding an array of complex factors – such as cultural, social, economic and geographical barriers, that result in low levels of access to and use of public health services by urban marginal, and particularly rural, groups. They have also recognized

the contributions brought about by indigenous knowledge, practices, resources and practitioners to improve the health status of these groups, as well as the need to find adequate strategies and fora to strengthen the former and promote a respectful and supplementary interaction between indigenous and official health systems.

Culture could be defined as a pattern of characteristic beliefs, thoughts, values, practices, communication, behaviours, view of the world and institutions (e.g. family, economic, political and religious institutions) that enable the preservation of a specific social group. Ethnicity, race, geographical environment and socioeconomic level, in different combinations, make up different cultural contexts.

Cultural barriers stem from a lack of understanding of cultural contexts. These often regard highly certain cultures to the detriment of others and, thereby, determine the place that each culture occupies within

national societies. Public services do not take into account differences between cultures regarding language and communication, values and beliefs, lifestyles and time conceptions. In turn, this creates **organizational barriers** in health services, translated in problems linked to health staff performance, opening hours, physical positioning and technical procedures used in public health services. Each one of these aspects represents as many inconsistencies between health services organization and delivery and the internal dynamics of multicultural peoples.

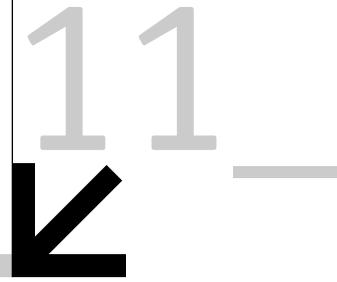
Social barriers are determined, for instance, by the level of education. Illiteracy rates among indigenous peoples are high, particularly among women. **Economic barriers** are linked to the financial difficulties people face to have access to health care due to their income level, the real costs of health services (transportation, food, accommodation, medicines, loss of income), specially during emergencies. Furthermore, several indigenous communities

use bartering as a means of payment, while this mechanism is not usually accepted by non-indigenous societies. **Geographical barriers** are related to the difficulties people face in seeking access to health care due to distances from health facilities, means of transport and seasonal geographical isolation.

Access is defined in terms of geographical viability. It has been established that urban population enjoys access to public health care services when the nearest facility is thirty minutes away in urban environments and one hour away in rural contexts. Nonetheless, it is suggested that this definition should also encompass problems related to cultural and economic barriers that condition people's real access to health services.

Quality

Quality, in general, and in operational terms in particular, is defined as "the characteristics of a good or service that meet the **expectations**



and needs of a customer or user". In operational terms, quality in health services implies "providing the beneficiaries of health services the assurance that they will receive the greatest possible benefits and that they will be protected from unnecessary risks". In this sense, quality has both a technical dimension and a dimension associated to the user's or patient's perception. Technical quality is linked to safety, effectiveness and usefulness of health care and perceived quality is linked to acceptability and warmth, in other words, it is associated with dignified treatment for patients and users. In sum, it means "doing the right things, the right way". (Muir Gray, in Infante A. *Garantía de la Calidad*. Power Point presentation, PAHO, 2005).

Traditional/Indigenous Health Systems

In this document, "traditional" medicine is understood as the health approach that encompasses a set of knowledge and practices of indigenous pre-Hispanic origin –and

in certain cases influenced by popular Hispanic and African medicine, which are clearly circumscribed to a specific view of the world. This knowledge is expressed orally, learnt empirically and transmitted through teachings, initiation, legacy or revelation by supernatural beings. Its logic transcends the understanding of health and disease as expressions of corporal functions and it is ruled and based upon a mythical religious and ideological foundation. The term traditional is understood in contrast with "modern" ways represented by the type of medicine based on biomedical principles. However, it is clear that the term traditional does not refer to static or atavist knowledge but rather to dynamic knowledge which is constantly updated in permanent syncretism.

Over time, the indigenous peoples of the Region have developed a set of practices along with knowledge about the human body and the harmonious coexistence with other human beings, with nature,

and with spiritual beings. The systems they have developed are very complex and well-structured both in their contents and their internal logic. Much of indigenous peoples strength and capacity for survival stems from the efficiency of their traditional health systems whose "conceptual axis", or view of the world, is based upon the principles of balance, harmony, and holism. This set of practices and knowledge of indigenous peoples in the Region, generally grouped under the expression "traditional medicine", shall be hereby referred to as Traditional Health Systems or Indigenous Health Systems.

Traditional Medicine includes an entire body of ideas, concepts, beliefs, myths, procedures and procedures or rituals (whether explainable or not) connected to the treatment of physical and mental illness or social imbalances in a particular individual community, or people. This body of knowledge explains the etiology, nosology and procedures for the diagnosis, prognosis, cure, and disease

prevention practices (WHO, 1977; Valdivia, 1986). This knowledge is transmitted orally and by tradition, from one generation to the other. Thus, this medicine is circumscribed, local, collective, anonymous, and carries a deep universal message. (Valdivia, 1986). Under the generally accepted concept, local health systems are the complex set of processes that constitute the totality of social action in health at local level, including, but not limited to, health services delivery (PAHO/WHO, 1993). Thus, traditional health systems are a particular type of local health system characterized by the concepts of all-inclusiveness and holistic approach that have been ever-present among indigenous peoples (Yáñez del Pozo, 1996).

Popular or domestic medicine

Popular or domestic medicine is understood as the set of resources available to the population to meet some of its health care needs. These

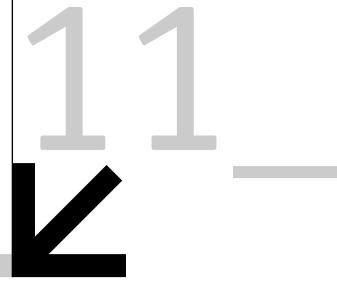
resources and knowledge are not circumscribed to a specific view of the world but consist of knowledge taken from different types of medicine (allopathy, traditional medicine, etc.). Popular medicine is usually practiced at home or as a first line of action before consulting health care services.

Harmonization of Conventional and Indigenous Health Systems

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. In this sense, it is 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 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. Though well-intentioned, these policies actually turned out to be ethnocidal. In formulating policies on indigenous peoples, indigenous representation was merely symbolic. (Stavenhagen, 1992).



Culture

Culture can be defined as a pattern of beliefs, thought, values, practices, communication, behaviours, view of the world, and institutions (family, religious, economic, and political) that are characteristic of and used to preserve a particular social group. (Cross N, Bagron, Dennis, and Isaacs, 1989). Ethnicity, race, and socioeconomic levels in various combinations shape the different cultural contexts (Pinderhudghes, 1989), to which it is necessary to add the geographical dimension.

Each culture, throughout its history, has developed different responses to fundamental problems. These responses stem not only from internal dynamics but –and largely, from external conditions. To face the specific problem of disease, different categories, models, ideas, practices have been developed by each culture linked to its view of the world, its social and economic history, as well as its geographical and natural context (Estrella 1977; Cáceres, 1988, Yáñez

del Pozo, 1995-1996). Therefore, these responses are far from identical and are not necessarily valid for all cultures.

View of the World

The view of the world is a conceptual axis on its own right. It encompasses a set of elements which determine the way in which different cultures tend to conceive the world and their place therein. Indigenous peoples' view of the world defines the relations among individuals and between individuals and society, Nature and spiritual beings. It is based on balance, harmony and holism.

As it is further explained below, several barriers in the interaction between cultures –in this case in health services, stem from a lack of knowledge about these elements of the social and cultural context of the population that receives healthcare.

Multicultural

Few studies do not describe the population in the

Americas as multicultural; this is, composed by several cultures. However, this descriptive concept –though valid and important, fails to identify these different cultures as stakeholders in current processes in the Region. The multicultural nature of the population is a reality and intercultural relations reflect the interaction among these cultures.

Intercultural Focus

The incorporation of the **intercultural approach to health** aims at strengthening non dominant cultures and raise awareness among dominant cultures by emphasizing their similarities and promoting a multi-angled learning process.

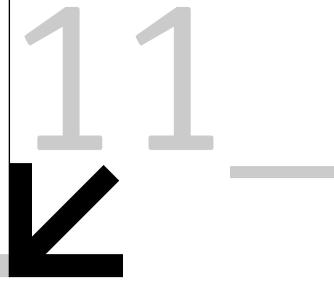
In intercultural paradigms, the concept of intercultural focus implies an interactive social process that –within a specific context, encompasses acknowledgement of and respect for political, economic, social, cultural, linguistic, gender and generation differences within and between cultures, and which is a vital foundation for a

fair society (PAHO, 1998). In the implementation of the social participation principle, supported by the health sector reform, the application of the intercultural approach to health must be based on dialogue, respect for diversity, democracy and participation with cultural interaction, consultation, consensus and goal-oriented collaboration (PAHO, 1998). The aim of this process is to contribute to the equitable access to quality health care translated in the timely, efficient and safe delivery of health services (technical quality), in an adequate physical environment, with appropriate ethical standards and warmth that reflect acceptance towards the user and his or her dignified treatment in health care services delivery (perceived quality) (Omram, 1997; PAHO, 1998; PAHO, 2005).

Sociocultural Analysis

From a conventional standpoint, when describing a marginalized population's living conditions and

health status there is a tendency to emphasize the lacking elements. 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 their individual capacities or perspectives. Sociocultural analysis, applied to indigenous peoples, starts with the official recognition of and respect for indigenous peoples. It takes into account the specific social, economic, cultural, demographic and political characteristics of the population and stands as a reference framework for the development of strategies, policies, plans, programmes and projects. In this case they are designed to contribute to indigenous peoples' wellbeing, but in general, they could be applied to other excluded groups. The reflection that intends to examine the correlation between different variables and their cumulative effect has been called socio cultural analysis.



WORKSHOP ON QUALITY STANDARDS IN HEALTH CARE SERVICES FOR INDIGENOUS PEOPLES

November 7 – 9, 2005
Quito, Ecuador
List of Participants

1. Dr. Guillermo Barragán, Ministry of Health, Ecuador
2. Dr. José Castro, Ministry of Health, Ecuador
3. Dr. Luis Felipe Codina, Focal Point, Health of Indigenous Peoples, PAHO/WHO-Ecuador
4. Mr. Franklin Columba, Foundation Taitas & Mamas Yachaks, Quito, Ecuador
5. Dr. Miriam Conejo, Director, Jambi Huasi, Indigenous Peoples and Peasants Federation of Imbabura
6. Dr. Washington Estrella, Ministry of Health, Ecuador
7. Dr. Juan Fernández, Advisor on Quality in Health Services, PAHO/WHO
8. Dr. Rodolfo de Jesús Guzmán García, Oportunidades Programme, México
9. Anthropologist Edgard Magalhaes, National Health Foundation, FUNASA, Brazil
10. Dr. Roberto Moreno, Ministry of Health, Panamá
11. Dr. Juan Naula, Director, National Directorate for Health of Indigenous Peoples, Ministry of Health, Ecuador
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WORKSHOP ON QUALITY STANDARDS FOR THE DEVELOPMENT OF INTERCULTURAL HEALTH MODELS IN AREAS INHABITED BY INDIGENOUS PEOPLES

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Quito, Ecuador

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