Indigenous Peoples and Health: Issues for Discussion and Debate

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Inter-American Development Bank

Sustainable Development Department

Indigenous Peoples and Community Development Unit

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Introduction

The Inter-American Development Bank (IDB) has been financing social programs in Latin America and the Caribbean since its very beginning. The IDB's earliest social programs, in 1961, were social projects aimed at providing potable water and basic sanitation. In 1973, the IDB began to finance health sector projects; and in the mid-1980s, the IDB began to finance programs specifically oriented toward benefiting the indigenous peoples of the region.

Until recently, the IDB's activities and operations for indigenous peoples did not primarily address health issues. Many programs may have had indirect effects on health, through the social improvements and empowerment they promoted, but they were not directly focused on health or indigenous medicine. Similarly, health activities and operations did not primarily address health issues of indigenous peoples. Many health programs affected health conditions for indigenous peoples, but they were not specifically designed or targeted for them. Only a few operations had components aimed at increasing indigenous peoples' access to health services through culturally sensitive expansions of national health systems.

Recently, several proposals have drawn into relief the need for a common IDB perspective on promoting indigenous peoples' health. In particular, it is clear that health specialists bring different concerns to evaluating and designing programs than do specialists on indigenous peoples issues. This discussion paper is aimed at making those differing perspectives explicit so that we can:

- use similar terminology and reduce misunderstandings;
- identify areas in which the perspectives concur; and
- identify and make explicit those issues on which there is disagreement so that more informed discussion and analysis can be undertaken.

The next section of this paper presents a summary of health specialist concerns, followed by a summary of concerns for those working on indigenous peoples' issues. The final section attempts to highlight areas of agreement and define questions for debate. In each section, the reader is encouraged to consider at least three levels of analysis: the conceptual framework, the implicit priority setting mechanisms, and technical proposals. Furthermore, it is important to keep in mind at least three different kinds of "health programs": those that aim to make "Western Medicine" available for indigenous peoples; those that aim to support and promote "Indigenous Medicine" (including medications and medical practices); and those that seek to integrate the two.

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[1] This discussion paper was written by Carlos Perafán (SDS/IND) and William D. Savedoff (SDS/SOC) in preparation for a seminar on Indigenous Peoples and Health, to be held at the Inter-American Development Bank in Washington, D.C. in February, 2001. It reflects discussions with health specialists and with specialists on indigenous peoples who are working at the IDB. However, the opinions expressed in this discussion paper do not represent an official position of the IDB and reflect only the views of the authors. It is presented in the spirit of focusing discussion and is not meant to be conclusive or final in any sense. Please direct any comments to Dr. Savedoff by email at bills@iadb.org.

Health Specialists: Concern for a Nation's Health

Because countries are the IDB's main clients, health specialists tend to focus on society-wide health conditions. Therefore, indigenous people's health and medical practices are viewed as part of a wider population with diverse needs. Second, specialists try to identify available policy instruments that they know to be effective in addressing the most pressing health concerns. These policy instruments include public health measures— such as vaccination campaigns, vector control, and education—and improvements in health services -- whether increasing access to basic care, mobilizing increased financing, changing resource allocation mechanisms, building clinics or hospitals, training medical personnel, or insuring citizens against catastrophic costs of severe illness. Priorities are supposed to be set by determining the most cost-effective policies that are politically, institutionally, and financially feasible.

Within this conceptual framework, programs are adapted to indigenous peoples based on the characteristics that differentiate them with respect to the rest of the population. These would include measures to make health services culturally sensitive and socially appropriate; and allocate resources toward illnesses or conditions that are prevalent among indigenous peoples (frequently these include reproductive health problems and infectious diseases).

The predominant view among the health specialists is that the Bank has historically tried to address the health needs of indigenous populations by supporting the extension of "official medicine" to indigenous populations in ways that are sensitive and appropriate to their cultures. There was a sense that recent requests go beyond such outreach activities to directly support non-Western medical treatments and practices.

Health specialists frequently express the view that many of the criteria that apply to evaluating "Indigenous Medicine" also apply to "Western" medical treatments and practices. If anything, the question was why the standards for evaluating "Indigenous Medicine" should be any less rigorous than those required of other health sector operations. Four general areas of concern can be identified: the definition of "Indigenous Medicine", establishing need and priorities, standards for safety and efficacy, and outreach.

Definition of "Indigenous Medicine"

The first concern is that "Indigenous Medicine" requires definition. Frequently, "Indigenous Medicine" is grouped with a wide range of practices under the category of "Traditional Medicine" that might indicate any non-Western allopathic treatment or practice. Clearly such a category would be meaningless for evaluative purposes since it is so heterogeneous. For the purposes of this document, the term "Indigenous Medicine" will be used to reflect the range of treatments and practices that are specifically indigenous to the Americas and practiced by indigenous peoples.[2]

Presumably, any Bank operation that proposes to study, incorporate, or support "Indigenous Medicine" should provide a sufficiently precise definition of the particular disease concepts and treatments that are under consideration so that they can be properly analyzed and, if approved, properly implemented.

[2] This clearly sets aside discussion of other "traditional" practices, such as those from the Far East (e.g. acupuncture) and "alternative" practices (e.g. homeopathy).

Needs and Priorities

The second concern is that Bank financing for "Indigenous Medicine" must respond to identifiable health problems that have relevance and priority for the country's health sector strategy. Respecting indigenous peoples' demands for indigenous medical treatments is important, as it is for other populations. But as with the health services provided or regulated by the Ministry of Health, respecting these demands has to be balanced against evidence of effectiveness and feasibility.

To address this concern, Bank operations that propose to study, incorporate, or support "Indigenous Medicine" should demonstrate the need for such treatments or practices in terms of (i) identifiable health problems in the beneficiary population, (ii) expected efficacy of the treatments or practices, and (iii) insertion in the country's national health strategy in dialogue with the IDB. In practical terms, studying, incorporating, or supporting "Indigenous Medicine" would then be carried out most effectively if they benefit from and contribute to larger health sector operations as a component or subcomponent of such operations.

Standards for Safety and Efficacy

The third concern is that Bank support for "Indigenous Medicine" should meet standards of safety and efficacy—safety because human health is involved, and efficacy to assure some impact from the use of scarce resources. These standards would apply to different practices and treatments, and not imply complete rejection of an entire system of medical practice. These standards presumably apply to Western Allopathic medical practices as well.

This would imply that Bank operations that propose to study, incorporate, or support medical treatments or practices should assure that the proposed treatments or practices pass internationally acceptable standards of safety and efficacy—either through (i) studies prior to approval[3], (ii) positive evaluation of the country's internal capacity for determining safety and efficacy, or (iii) reserving the right of objection over consultants or firms contracted to make such determinations.

Outreach to Indigenous Groups

The Bank has financed health sector operations that seek to improve the health of populations that may be distinct from the culture in which the medical service system is currently situated. For Bank operations, this has usually arisen in the case of groups that have different languages or ethnicity.[4]

This may already be an accepted practice in Bank operations, but could be made more explicit and improved. Bank operations that propose to address health needs of culturally distinct groups—particularly due to linguistic or ethnic differences—should seek to incorporate practices and treatments in ways that are culturally sensitive and acceptable. In those cases where human resources for health promotion and treatment are scarce, "indigenous" healers can be trained in acceptable treatments and practices to serve their populations.

Summary

In sum, health specialists would say that the following four questions need to be answered by operations that seek to study, support, or incorporate "Indigenous Medicine". Presumably, these questions are already being addressed by IDB health sector operations.

[3] For example, Germany's "Commission E" has extensive compilations of such studies, see Blumenthal, et al 1998.
[4] See, for example, IDB (1999a) and IDB (1999b).

1. Is there an identifiable health problem of sufficiently high priority that would be measurably improved by the activities?
2. Does the activity complement the national strategy and the IDB's health strategy, if any, for that country? In particular, is the proposed operation the best use of scarce external financing for the health sector?
3. Do medical treatments or practices financed by the operation meet tests of proven efficacy and safety, according to internationally accepted standards, such as those used by WHO, the FDA (USA), or the Commission "E" (Germany)?
4. If culturally distinct groups are to be beneficiaries of the proposed operation, are the activities designed to be culturally sensitive and appropriate?

Specialists on Indigenous Peoples: Respect, Dignity and Understanding

The IDB first hired a specialist on indigenous peoples as part of its environmental division, responsible for mitigating the social impacts of its many infrastructure projects. The IDB soon began to finance operations specifically oriented toward benefiting indigenous peoples, through social investments and empowerment. An important milestone was the creation of the "Fondo Indígena", a development fund managed by indigenous peoples to finance projects proposed by indigenous communities themselves.

Specialists on Indigenous Peoples at the IDB come to projects with a focus on the indigenous peoples as subjects, not objects, of development projects. They identify potential beneficiaries and, to the extent possible, aim to address the development needs articulated by those beneficiaries. In doing so, the specialists seek to understand the full context and characteristic of the particular communities in which the project will operate. In this way, the project should address what the indigenous peoples may see as whole, but which "Westerners" commonly separate into social, economic, cultural, religious and other dimensions.

The predominant view among specialists on Indigenous Peoples is that IDB projects, like many government programs in the region, tend to design and implement development projects that affect indigenous peoples without sufficient community participation or sufficient understanding of the world in which these projects will be executed. Such programs are regularly promoted and implemented with arrogance and a patronizing view of the people who are expected to benefit. Consequently, many programs that are aimed at improving the conditions of indigenous peoples can be ineffective or even harmful. And, unfortunately, there are many experiences to support such a view.

For specialists on indigenous peoples, the expression of interest by indigenous communities for projects to support, promote, or extend indigenous medicine should be sufficient justification for supporting such programs. Indigenous medicines and medical practices are culturally rooted and socially important. They address ailments that in some cases "Western Medicine" does not even recognize as ill health, but which are serious and real in the indigenous peoples' world and world view. Frequently, indigenous medicines and medical practices are also shown to be "cost-effective". Among these specialists, four key concerns can be discerned with respect to health programs for indigenous peoples.

Legal Framework and "Pluriculturalidad"

The first concern is that government and IDB-financed programs must respect the full rights of indigenous peoples. At the highest level, most constitutions in Latin America have adopted clauses that protect pluralism ("*pluriculturalidad*"). These constitutional provisions generally provide legal protection

to indigenous groups to live according to their own ways -- including their medicines and medical practices.

Indigenous peoples are not living in isolation of the nation state, and have equal rights to the guarantees of health for all citizens. To fulfill such guarantees, policies need to assure that health services and programs are *appropriate* to the indigenous culture. They also have to be *coordinated* with the communities' own activities and practices. This requires *good communication*, mutual respect, and good faith between "Western" and indigenous health practitioners.

These rights, as citizens, to health care require governments to extend the scope and quality of their health services. Providing access to care is important to reducing the degree of social exclusion that indigenous communities face. But if this is done in ways that recognize and complement indigenous medicine and medical practices, then it may be less costly than simply trying to "replace" it.

Indigenous Views of "Health"

The second concern is that health programs do not address health as it is understood by the indigenous communities. Indigenous peoples throughout the Americas have a worldview in which there are few boundaries between the natural world and people, and ill health can derive from imbalances in nature, as well as from hexes and sorcery. At a minimum, "Western" medical practice should not belittle these notions as they are real in their social importance, and for personal behaviors and well being. More appropriately, "Western" medical practices should recognize these as legitimate health concerns, and support the indigenous treatments and practices that address them.

Specialists argue that these indigenous views are not heterogeneous. Rather they maintain that these views are remarkably similar among the indigenous peoples of the region. These societies all tend to view illness as a consequence of imbalances in nature or personal behavior. In almost all cases, different kinds of practitioners are available to address different classes of ailments. Certain basic treatments, such as those related to bone-setting or midwifery for normal births, are dealt with by practitioners with experience in these areas (e.g. *parteras* or *sobanderos*). Other kinds of ailments are addressed by "herbalists", whose expertise involves knowing the range of available substances that can be used for healing (e.g. *curanderos* or *botánicos*). Finally, there is another group of practitioners who largely deal with ailments associated with hexes or sorcery (e.g. shamans).[5]

Health practices within this indigenous paradigm are not exclusively related to individual physical illnesses. They also address "illnesses" related to the society and the environment as a whole. For example, health treatment skills are imparted to adolescents in rituals associated with passage into adulthood among Tukano's Yurupari. Communities also give special meaning to their land uses or social practices in relation to individual and communal health. The individual's well being is therefore linked to that of the community and the environment through practices (most of them shamanic) that pursue spiritual equilibrium—an equilibrium between individuals, communities, and their environment.

Limits of Both Systems

The third concern is that "Western" medicine does not recognize its own limits when it seeks to displace indigenous practitioners. Indigenous medicines and medical practices have their limits, but so does "Western" medicine. It is important for both systems to recognize their limits, areas in which they may

[5] This characterization of the indigenous worldview is clearly incomplete and simplistic. It is presented here only to give the reader a sense of the kinds of issues that can arise with different classes of ailments between "Western" and Indigenous medicine. For a more complete exposition, see Faust (n.d.) and PAHO (2000).

have no particular expertise, along with those areas in which they can complement one another. Presumably, individuals make good decisions about what kind of practitioner can best address their ailments. Indigenous peoples have a different classification system for diseases, such as *mal de ojo* or *mal viento*, where an individual would seek the advice of a sorcerer. Yet, the same person who contracts a disease that they identify with "Western" medicine, such as tuberculosis or measles, would consult a "Western" doctor. Studies have shown that people will seek out a shaman to deal with a suspected hex or a psychological or social disorder, while they will seek out *curanderos* or "Western" doctors for illnesses that are recognized as treatable under those frameworks.

Another limitation on "Western" medicine is its cost and accessibility. While "Indigenous Medicine" is widespread in Latin American countries, official health systems are often restricted to urban and non-indigenous populations. Replacing "Indigenous" with "Western" medicine would not only require the acceptance of indigenous and mestizo populations but it would also require an outlay of resources that countries are probably not able or willing to commit.

Intellectual Property Rights

The fourth concern is that at the same time that "Western" medicine has tried to supplant indigenous medicine, international companies are stealing and profiting from the indigenous peoples' store of knowledge. The pace of pharmaceutical research and development in wealthier countries has accelerated, and the demands for identifying new and useful substances are increasing rapidly. Indigenous peoples feel that it is unjust for pharmaceutical companies to reap large monetary benefits from exploiting techniques and medications that were developed through years of intergenerational transmission of knowledge within their communities. In some cases, like Panama, explicit legal norms have been issued to protect these indigenous claims to intellectual property rights. But in many cases, countries have no provisions, nor have they clarified the conditions under which these property rights can be defended. Meanwhile, international trade negotiations have led to agreements (particularly T.R.I.P.S.) that signatory nations are required to implement, and which do not necessarily accommodate indigenous claims to such intellectual property rights.

Summary

In sum, specialists on indigenous peoples would argue that the following four questions need to be answered by operations that seek to study, improve or expand health services for indigenous peoples.

1. Is the program designed to respect constitutional protections for indigenous practices, and to fulfill constitutional guarantees of access to good quality and appropriate health care services? Has it been developed with real participation by the indigenous population so that they can consider themselves subjects and not objects of the activities?
2. Does the program recognize and respond to differences in worldviews, definitions of disease, and beneficiaries' demands for health services?
3. Does the program recognize the limits of "Western" medicine, and has it properly evaluated and considered the positive role indigenous medicine and medical practices can play in improving effectiveness of care, reducing costs, dealing with psychological and social health issues?
4. Does the program address concerns over intellectual property rights for medicines and treatments that derive from indigenous practices?

"Western" Meets "Indigenous": Agreements and Disagreements

It appears that the specialists in health and on indigenous peoples have a number of areas of agreement, and several areas in which there is no clear concurrence.

Areas of Apparent Agreement

Indigenous medical practices should not be repressed or eliminated. Rather they deserve respect as part of indigenous peoples' culture and practices.

Public health programs and services should be extended to indigenous communities. These services should be of good quality and be appropriate (*adecuado*) to the particular character and needs of the indigenous population. Examples of such appropriate extensions of "Western" medicine would include hiring or training bilingual staff, including indigenous communities in managing health facilities, paying attention to taboos related to gender and age differences, or modifying the design of hospitals and other facilities (e.g. "intercultural hospitals").

Where possible, indigenous medical practitioners should be valued as part of the health service system. In this, there can be agreement with regard to practitioners like bone-setters and midwives (if "properly" trained), and some agreement with regard to *curanderos* (i.e. conditional on the kinds of medicines and illnesses treated). There is considerably less agreement on the role of shamans in the public health system (see below). Nevertheless, there is agreement on the necessity to coordinate treatments given to the same patients so as to avoid complications.

Health specialists have no particular position with regard to intellectual property rights over indigenous medicines. To the degree that the IDB begins to address pharmaceutical sector issues, staff will have to discuss and develop a position on this issue, in consultation with other groups such as those promoting regional integration of trade.

Areas of Apparent Disagreement

There appear to be three major areas in which there is no clear agreement: priority setting, what criteria are used to determine legitimate medical practices, and what is the scope of the health sector.

Among health specialists, priority setting for public policy requires a consideration of the entire country's health needs, the available resources, and the best application of those resources to serve as many people as possible. This is not necessarily in conflict with a view that indigenous peoples should set their own priorities for health care, but each of these approaches can, and probably will, lead to different priorities. Can these differences be accommodated?

Secondly, among health specialists, there are basic criteria that all health operations should follow, such as demonstrated need, efficacy, and safety. The accepted arbiters on whether medical practices meet these criteria are all operating in a "Western" mode of evaluation -- even if they evaluate alternative and indigenous medicines (e.g. Germany's Commission "E"). For indigenous specialists, the community of indigenous practitioners is considered a legitimate source of expertise regarding these criteria. Is it possible to agree on legitimate authorities? Will one side have to cede to the other in all cases, or only in some cases? In which cases would different frameworks apply? What would be an acceptable methodology to evaluate Indigenous Medicine treatments, especially shamanic practices?

Finally, what range of "ailments" is considered to be within the scope of health sector operations? Many of the ailments treated by bone-setters, midwives, and *curanderos* are similar to ailments treated by western medical practitioners. Should these be incorporated into public health systems? Should national health systems address the kinds of ailments treated by shamans?

Hopefully, this paper will contribute to a fuller understanding between health specialists and specialists on indigenous peoples. If areas of common agreement can be found, then there are grounds for making activities compatible. On areas of disagreement, more discussion, evidence, compromise or high-level policy decisions will have to follow.

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