Intercultural Health
From Theory to Practice

Executive Summary
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Introduction

Intercultural health is the integration of Western and traditional medical practices into a comprehensive system that promotes enhanced health outcomes. It plays a crucial role in healthcare strategies for Indigenous populations in various countries. This Executive Summary outlines the fundamental concepts of Intercultural Health via its historical, political, theoretical, and practical dimensions.

Background

Until a few decades ago, traditional medicine was often stigmatized as superstitious and ineffective. However, since the 1970s, a series of global institutional declarations, agreements, and conventions have underscored its significance:

- **Alma-Ata Declaration (1978):** This declaration emphasized the critical role of traditional medicine in primary healthcare. It defined health as a "complete state of physical, mental, and social well-being, and not merely the absence of disease," a definition resonating with the holistic perspectives inherent in traditional societies.[1]
- **International Labour Organization (ILO) Convention 169 on Indigenous and Tribal Peoples (1989):** This convention provided substantial support for the grievances of Indigenous peoples. It highlighted the necessity to value traditional medicine and adapt official health systems to their social, economic, and cultural conditions.[2]
- **United Nations Declaration on the Rights of Indigenous Peoples (2007):** This declaration affirmed Indigenous peoples' rights to their "own traditional medicines and to maintain their health practices, including the conservation of their medicinal plants."[3]

Inspired by these documents, the World Health Organization (WHO) has advocated for the effectiveness of traditional medicine and the need for its integration into official health systems. Through these efforts, it developed the WHO *Traditional Medicine Strategy 2014-2023.*[4]

Institutional framework

LATIN AMERICA. There are 700 Indigenous groups in this region, which equates to around 50 million people. The health indicators of these communities are typically lower than the rest of the general population. The Pan American Health Organization (PAHO)'s 2017 *Policy on Ethnicity and Health* acknowledged this issue and recommended establishing a dialogue to develop knowledge around culturally appropriate health care. This approach has been set up differently in each country.[5]

- **Bolivia.** The Political Constitution of the Plurinational State of Bolivia establishes the State's obligation to promote traditional medicine and created a Vice Ministry of Traditional Medicine and Interculturality.[6]
- **Brazil.** Within the Unified Health System, the Subsystem of Health Care for Indigenous Peoples and the National Policy of Health Care for Indigenous Peoples were created to unify Indigenous traditional health systems with the biomedical system.[7,8,9]
- **Colombia.** In 2010, the National Assembly of Health of the Peoples proposed the Indigenous System of Self-Determined and Intercultural Health.[10]
- **Ecuador.** The Constitutional Charter of Ecuador defends the need to protect traditional medicine practices and recognizes that interculturality is the foundation of the National Health System.[11]
- **Mexico.** There is the Directorate of Traditional Medicine and Intercultural Development within the Ministry of Health in Mexico. The General Health Law recognizes the importance of traditional medicine for Indigenous peoples.[12]
- **Peru.** The General Health Law promotes traditional medicine, which should be a priority for the State.[13]

AFRICA: Approximately 80% of the African population relies on traditional medicine as their primary healthcare.[14] In recent decades, numerous African countries have sought to integrate traditional medicine into their healthcare systems.

- **Ghana:** This is a paradigmatic example of intercultural health policies in Africa. Since 2001, various initiatives have been in the process of incorporating and legitimizing "herbal medicine" within the official healthcare

system. This includes launching academic programs and establishing traditional medicine policies and governmental bodies to promote and regulate these initiatives.[15]

Australia: Healthcare for Indigenous peoples in Australia is coordinated by the National Aboriginal Community Controlled Health Organisation (NACCHO), representing 144 Aboriginal Community Controlled Health Organisations (ACCHOs) across the country. Within this framework, there are about 300 clinics nationwide that provide holistic, comprehensive, and culturally competent primary healthcare services according to NACCHO.[16]

Intercultural health models

Following the political and normative processes outlined, numerous practical intercultural health experiences have emerged, which can be divided into three major categories:

- **Intercultural Sensitivity Model:** This model does not integrate traditional medicine into the official healthcare system but adapts it to the sociocultural needs of Indigenous patients. A typical feature of this model is having linguistic and cultural translators who are generally locally trained nursing assistants.
- **Parallel Intercultural Model:** Traditional medicine is provided within the official health system, but there is no integration with Western medicine to create a new paradigm. An example of this model is found in hospitals where facilities for both modalities exist, allowing patients to choose the type of medicine they wish to receive.
- **Integrated Intercultural Model:** Critically speaking, this is the only genuine intercultural model since it is the result of the unification of modern and traditional knowledge. This approach has traditional and Western medical practitioners organically collaborating during patient treatment.[17]

Critiques, challenges, and complexities

Social researchers have identified several challenges to overcome to successfully implement intercultural health projects:

- **Biomedical Positivity:** Western professionals, with a strong formal education, often struggle to equate their practices with those of traditional healers.[18]
- **Dosage:** Plant-based medicinal preparations are viewed with skepticism due to a lack of standardization. There is also limited comprehensive knowledge about their active principles, contraindications, and precise dosing.
- **Institutionalization:** Integrating traditional medicine into the official biomedical system involves registration, certification, and sanction. Can regulatory bodies, with a distinct biomedical affiliation, regulate traditional medicines? And if so, would these medicines remain traditional?[19]
- **Registration:** There are no official records of traditional healers to ensure their legitimacy. This makes it challenging to distinguish a legitimate healer from a charlatan in the Western context.[18,19]
- **Bureaucracy:** Hiring in highly bureaucratized official health systems requires academic certificates, bank accounts, etc., which traditional healers usually do not have.[18,19]
- **Agreement:** Large state policies on intercultural health rely on extensive legal and institutional structures, but often they do not result from community consensus.[20]
- **Witchcraft:** In many Indigenous societies, traditional healers can be considered witches who cause illness in some communities or families. This could be problematic if a particular traditional healer were to treat some of these fellow community members.[21]

Final considerations

Intercultural health is effective when correctly designed, yet numerous initiatives have failed. Here are some key considerations to bear in mind when developing intercultural health programs.

Implementing a model of intercultural sensitivity requires:

- **Training:** Western health professionals should understand traditional health systems, their effectiveness, relevance, and the historical circumstances that have led to the discrimination of Indigenous peoples.
- **Mediation:** When dealing with Indigenous populations, official health systems should devise effective ways to mediate between healthcare professionals and patients. Ideally, Indigenous patients should be treated by professionals who share their language and culture.
- **Holism:** The design of primary health care in communities should be based on a profound understanding of the social, productive, ritual, familial, and community context. This is in line with the Alma-Ata definition of health, "a complete state of physical, mental, and social well-being, and not merely the absence of disease."[17]

For initiating parallel and integrated models, the recommendations made by the Australian Indigenous Doctors Association (ANTAC) have successfully been integrated into Adelaide's official health system:

- **Organization:** Establishing an organization as a central body for the coordination, administration, and provision of services by traditional doctors.
- **Accreditation:** Enables an accreditation process for traditional doctors with standards of qualification, accreditation, and registration to be recognized as legitimate health professionals.
- **Registry:** A public registry of accredited traditional doctors was put in place.
- **Bureaucracy:** There is a hiring process for traditional doctors based on a state model, along with economic compensation comparable to that of Western doctors.
- **Database:** A systematic database was created based on the interventions used by traditional doctors.
- **Training:** Training and development modules were created for healthcare professionals on the role of traditional doctors in healthcare.[17]

It should be acknowledged that many of these measures adapt the dynamics of Indigenous societies. However, we also believe this is the only way the dominant system will adopt them, which in turn will support the most disadvantaged people's health.

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