

# **Beyond Diversity in Indigenous Health: Developing Research that Reveals Inequities and Promotes Social Justice<sup>1</sup>**

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## Abstract

The purpose of this article is to highlight the importance of developing different research which, beyond the description of the different practices and knowledge of the indigenous communities, reveal the inequalities and social injustices that they live in. The argument is based on three moments of research: a qualitative study conducted during 1992 and 1993 with the indigenous peoples of Colombia from different regions of the country. A documentary research on health carried out in Colombia from 1935 to 1996, with the indigenous and Afro-Colombian population, and a review of the recent research on the health of the indigenous peoples from Colombia. The first part of the article presents a review of the concepts of social justice and equity, within the context of the Declaration of Alma-Ata and the framework of the social determinants of health. Then, an analysis of the situation of the indigenous peoples in Colombia is made -from the research on their health-, and five critical issues between indigenous health and equity are taken into account: land: property, violence and forced migration. Resources and Environment: poverty and possessions. Power: self determination, abuse and dependence. Identity: discrimination and recognition. Health status: tradition and modernity. I intend to analyze the Colombian case in order to provide elements to the understanding of the health problems of the indigenous peoples in other contexts. The article concludes with some recommendations on global and local actions in indigenous health.

*Key words:* health of the indigenous peoples, Colombia, social inequality, social justice.

*Key words plus:* Indigenous health, Social Inequity, Social Justice.

## **Más allá de la diversidad en la salud indígena: desarrollando investigación que revele las inequidades y que promueva la justicia social**

### Resumen

El propósito de este artículo es resaltar la importancia de desarrollar investigaciones que, yendo más allá de describir las diversas prácticas y conocimientos de las comunidades indígenas, revelen las inequidades e injusticias sociales que ellos viven. La argumentación se basa en tres momentos investigativos: un estudio cualitativo realizado durante 1992 y 1993 con indígenas colombianos en diferentes regiones del país; una investigación documental sobre investigaciones en salud realizadas en Colombia de 1935 a 1996, con poblaciones indígenas y afrocolombianas, y una revisión de la investigación reciente sobre la salud de los indígenas colombianos. En la primera parte del artículo se plantea una revisión de los conceptos de justicia social y equidad en el contexto de la Declaración de Alma Ata y del marco de los determinantes sociales de la salud. A continuación se analiza la situación de los indígenas en Colombia en la investigación realizada sobre la salud de los pueblos indígenas en Colombia y en cinco problemas críticos en la relación entre salud indígena y equidad: la tierra: propiedad, violencia y migración forzada; recursos y medio ambiente: pobreza y posesiones; poder: autodeterminación, abuso y dependencia; identidad: discriminación y reconocimiento; situación de salud: tradición y modernidad. Mi intención al analizar el caso colombiano es dar elementos para la comprensión de los problemas de salud de poblaciones indígenas en otros contextos. Se concluye con algunas recomendaciones sobre acciones globales y locales en salud indígena.

*Palabras clave descriptores:* Salud indígena, inequidad social, justicia social.

## **Além da diversidade na saúde indígena: desenvolvendo pesquisa que revele as iniquidades e que promova a justiça social**

### **Resumo**

O propósito deste artigo é salientar a importância de desenvolver pesquisas que, indo além de somente descrever as diferentes práticas e conhecimentos das comunidades indígenas, também revele as iniquidades e injustiças sociais que eles vivem. A argumentação baseia-se em três momentos investigativos: um estudo qualitativo realizado durante 1992 e 1993 com indígenas colombianos em diferentes regiões do país; uma investigação documental sobre pesquisas sobre saúde feitas na Colômbia de 1935 a 1996, com populações indígenas e afro-colombianas, e uma revisão da pesquisa recente sobre a saúde dos indígenas colombianos. Na primeira parte do artigo é apresentada uma revisão dos conceitos de justiça social e equidade no contexto da Declaração de Alma Ata e do entorno dos determinantes sociais da saúde. Posteriormente é analisada a situação dos indígenas na Colômbia na pesquisa feita sobre a saúde dos povos indígenas na Colômbia e em cinco problemas críticos na relação entre saúde indígena e equidade: a terra: propriedade, violência e migração forçada; recursos e meio ambiente: pobreza e posses; poder: autodeterminação, abuso e dependência; identidade: discriminação e reconhecimento; situação de saúde: tradição e modernidade. Minha intenção ao analisar o caso colombiano é dar elementos para a compreensão dos problemas de saúde das populações indígenas em outros contextos. Conclui-se com algumas recomendações sobre ações globais e locais em saúde indígena.

*Palavras chave:* saúde das populações indígenas, Colômbia, iniquidade social, justiça social.

*Palabras chave descriptor:* Saúde indígena, iniquidade social, justiça social.

*The existing gross inequality in the health status of the people particularly between developed and developing countries as well as within countries is politically, socially and economically unacceptable...Primary health care is the key to attaining this target as part of development in the spirit of social justice. (1)*

*Simply, the Commission will seek to have public policy based on a vision of the world where people matter and social justice is paramount. (2)*

*Social injustice is killing people on a grand scale. Social justice is a matter of life and death. It affects the way people live, their consequent chance of illness, and their risk of premature death. (3)*

## **Introduction**

Health, social justice and equality can be abstract ideals, but they are also goals for many health workers and researchers who struggle to make their daily realities for people around the world. In 1979, as a student in a community nursing class, I remember how enthusiastic our teachers were the day they told us the *Alma Ata Declaration* had been signed. Our teachers were excited by the Alma Ata goal “Health for all by the year 2000”, and the *Primary Health Care* (PHC) strategy (1). In the following weeks, I learned about the Chinese barefoot doctors, and the *Promotoras Rurales de Salud* (Rural Health Promoters), that existed in Colombia since the 1950s (4). Three years later, during my first job as a nurse under the mandatory social service in Guateque, near Bogota, I was assigned to lead a group of thirty-two *Promotoras Rurales de Salud* (Rural Health promoters). I remember their hard work, as well as their pragmatism and idealism mix ideas, and their daily struggles with the many health problems of their communities that weren’t able to solve. At the same time, I was interacting with physicians, and other health care workers who rarely went out to the rural area. Being in this particular context, I began to learn about the achievements, issues, challenges, and enemies of PHC. In 1992, after several years working as practitioner, and teacher in neonatal intensive care units, and pediatric community clinics, I participated along with colleagues and students, in a large project called *Gran Expedición Humana* (Great Human Expedition [GHE]) from October 1992 to July 1993 (5). In the course of this project, we conducted research and provided health services to isolated indigenous communities in Colombia. From these and other experiences with peasants, indigenous peoples, women, children, and diverse population that range from low to high income in rural and urban communities,

I learned about the possibilities and value of research in order to unveil their hidden realities. I think that research can be a good mean to promote social justice and equality.

The main purpose of this article is to discuss the importance of creating a continuous' research development that starts by describing the diverse practices and knowledges of indigenous communities, and then continuous to reveal the inequalities and social injustices in which they live. I will first discuss social justice and equality in the Alma Ata Declaration's context, and the current global framework on the *Social Determinants of Health*. Following the situation's analysis of Colombia's indigenous population, I focus on two topics: Research conducted on indigenous peoples' health and five critical issues of indigenous people's health and their relation to equality. By analyzing the Colombian case, my intention is to provide elements for understanding critical issues of indigenous peoples' health in other contexts.

## **Social Justice and Equality**

Following Braveman (2010), equality means justice. Health inequalities are the "systematic, plausibly avoidable differences in health, varying according to levels of social advantage, with worse health occurring among the disadvantaged" (6). Social disadvantages are related not only to unfair distribution of wealth, but also to inequalities on prestige, knowledge, power, and social acceptance.

The *Declaration of Alma Ata* (1), adopted in 1978 during the Alma Ata meeting, was the first time that the international community spoke out about social justice and equality in health. The meeting in Alma Ata was summon to talked about two discussed areas in the 1970s: Western medical model (7-13) criticism, and recognition of traditional and indigenous' importance in the health systems (14). The Declaration signed by 134 countries (15), reassured health as a fundamental human right, and found unacceptable the serious inequalities in people's health situation among and within countries; asserted health as being essential to economic and social development; supported both the role of governments and communities in their right and duty with their populations' health; and promoted community participation, cultural diversity and self-determination of local and indigenous communities. Following the declaration, PHC was adopted by different countries, including Colombia, as a central strategy to increase access to health care services. But since in its purpose failed to reduce inequalities and improve the health status of excluded and poor populations, it has been regarded by some people as a failed dream that never came true (15).

Although social justice and equality are ideas in the background of the *Ottawa Charter* and the model of *Health Promotion* (HP) known

thoroughly during the 1980s and the 1990s, HP focuses on developing five key action areas: Building a healthy public policy, creating supportive environments for health, strengthening community action for health, developing personal skills, and re-orienting health services.

It was not until the 2000s that social justice and equality re-emerged as central purposes in the arena of international health organizations. In March 2005, the Commission on the Social Determinants of Health (CSDH):

[...] was established to support countries and global health partners to address the social factors leading to ill health and inequities. It drew the attention of society to the social determinants of health that are known to be among the worst causes of poor health and inequalities between and within countries. (16)

The Commission was a global network integrated by policy makers, researchers, and civil society organizations that supported the World Health Organization (WHO) from 2005-2008 to tackle the social causes of poor health and avoidable health inequities.

The Commission published several reports based on experiences with several actors and stakeholders, including indigenous peoples (17), and on the analysis of world literature on Social Determinants of Health. The final report, published in 2008, identified three principles of action, all relevant for our interest on the intersection between indigenous health and equality:

- *Improve the conditions of daily life* – the circumstances in which people are born, grow, live, work, and age.
- *Tackle the inequitable distribution of power, money, and resources* – the structural drivers of those conditions of daily life – globally, nationally, and locally.
- *Measure the problem, evaluate action, expand the knowledge base, develop a workforce* that is trained in the social determinants of health, and raise public awareness about health's social determinant. (3)

In the context of the CSDH, improving indigenous peoples' health means promoting social justice and equality. Research is a critical and powerful means to improve life's conditions, tackle inequitable distribution of power, money, and resources, and measure, evaluate, and expand the ground knowledge, to transform unfair social realities. These purposes are particularly relevant for Colombia, which is one of the eleven most unequal countries in the world with a Gini coefficient of 57.6 (18), and where very few resources are allocated to research unfairness and social justice. Following, I would discuss how this framework relates to the situation of Colombian indigenous peoples.

## Colombian Indigenous Peoples

The 2005 Colombian Census estimated that the population in Colombia was 41,468,384 people (19). The population includes a few Caucasian background people, but the majority are *mestizo*. There are also four self-recognized ethnic collectives that represent 13.8% of the total population: African descendents living in the mainland, *Raizales* or African descendants living in two Caribbean islands (*San Andres* and *Providencia*); *rom* or gypsies, and indigenous peoples. African descendents are the largest minority group (10.4%), followed by indigenous peoples who represent 3.36% of the total population.

In Colombia, 67.7% of the 1,392,623 indigenous peoples are spread throughout Colombian territory in 710 communities (20). As a result of centuries of external and internal colonization, most indigenous peoples were obliged to move out to marginal lands, instead of keep living in their fertile and rich territories they once inhabited, such as the southeastern regions of Amazonia and the Orinoquia plains, Pacific Coast, the highest lands of the mountains in the central Andean region, and the northeast desert in the Guajira peninsula. As I will discuss later, in the last few decades indigenous peoples have continued to be displaced from their territories.

Indigenous peoples in Colombia are very diverse. After Brazil and Mexico, Colombia has the highest number of ethnic groups in the Americas (21). Government sources state that they belong to 87 to 90 ethnic groups (20, 21), but the *Organización Nacional Indígena* (Indigenous National Organization, ONIC) affirms that there are 102 different ethnic indigenous groups (20). They speak 65 different languages from 12 linguistic families (22). Those who live in rural areas participate in activities that range from hunting, harvesting, fishing and traveling and horticulture, to agriculture and cattle pasturing. Since diversity is also an outstanding characteristic of their health systems, describing, studying and analyzing the diversity of their health practices, knowledge and institutions, has been a central purpose of the research conducted on indigenous health in Colombia.

## Studying the Diversity of Diseases and Health Systems. Review of Purposes of Health Research with Colombia's Indigenous Populations

In 1997, as advisor to the National Program of Health Science and Technology, I worked on a documentary study on health research conducted in Colombia with indigenous peoples and African-Colombian populations from 1935 to 1996. The resulting data base includes 477 documents distributed among the following in table 1.

**TABLE 1.** Themes on Health Research

Theme	Documents	%
Infectious and parasitic diseases	199	41.7
Socio - anthropology	83	17.4
Genetics	44	9.2
Demography	41	8.6
Dentistry	30	6.3
Nutrition	27	5.7
Health systems and health services	27	5.7
Other pathology	26	5.4
Total	477	100.0

SOURCE: Duque MC. Health research about indigenous peoples and African Colombians; 1997.

Based on that study and on a current review of recent documents, the research on indigenous peoples' health in Colombia has had four focus: Studying the diseases; recognizing the diversity; studying the health systems, and including indigenous peoples in participating studies. As I will discuss later, most of the studies have not deal with issues related to social justice equality or power. Rather, the emphasis has been on describing diversity among these populations.

### Studying Disease in a Clinical and Epidemiological Framework

Of the documents reviewed, 68% focused on diseases from a biomedical perspective. These research documents are not so much about indigenous peoples or their health situation, as they are about diseases, mainly infectious and parasitic diseases or infectious agents common in the rainforest and other regions where they live. These include *arbovirus* or arthropod-borne viruses, *bartonellosis*, *brucellosis*, cholera, dengue, Venezuelan equine encephalitis, entomology, yellow fever, *philariasis*, hepatitis, retrovirus, syphilis, toxoplasmosis, influenza, vaccine-preventable diseases, leishmaniasis, malaria, mycoses, human papillomavirus, *paragonimosis*, intestinal parasites, *parotitis*, rabies, rubella, typhus, toxoplasmosis, *trypanosomiasis*, and tuberculosis. There are also studies on less common infectious diseases such as HIV-AIDS. Research studies on non-infectious health issues include those dealing with abortion, anemia, cancer, immune diseases, ophthalmologic diseases, *lipemia*, visual and hearing screening, nutritional diseases, *actinig prurigo*, genetic diseases, and dental problems. A few documents on mental health are focused on documenting what researchers regard as "exotic" behaviors.



## Recognizing the Diversity within an Anthropological – Interpretative Framework and a Mixed-Descriptive-Analytic Framework

Several studies about health system diversity have been conducted mainly by anthropologists and in a few cases by Nurses, physicians and dentists. Among the topics and the approaches studied are: Ethnographies of indigenous groups, health care practices and women, children and adults' care, historical analyses of diseases and malformations, health situation, traditional medicines, *curanderism*, *ethnobotany*, food and other substance-uses in traditional medicine such as tobacco and urine, physical anthropology related to nutrition and public health and traditional medicine, and studies about the relationship between religion, traditional medicine, and popular culture.

In the context of describing the diversity of indigenous health systems, it is important to see the research study called "Health Care in Health and Disease Processes in Indigenous and Isolated Communities in Colombia" developed by Javeriana University Faculty of Nursing, within the GEH.

The GEH was an interdisciplinary research and service project led by the Human Genetics Institute from Javeriana University in which 320 professors, investigators and students from Javeriana and other universities in Colombia participated. The GEH Team traveled throughout the country from October 1992 to July 1993. During this time we visited more than 50 indigenous peoples' groups, African-Colombians and *mestizos* from isolated zones. The purpose of these visits was to describe their biological characteristics within their cultural context, and to provide health services. The health services offered ranged from a variety of disciplines including nutrition, clinical laboratory, health education, optometry, ophthalmology, medicine, dentistry, and nursing care. Investigations were undertaken in different scientific and cultural fields: Architecture, dentistry, design, demography, economics, genetics, medicine, music, nursing, painting and sculpture.

Up to the present day, there have been more than 100 national and international articles published that came from the GEH Project; twelve research reports, three books with artistic drawings and paintings, and a CD with indigenous and afro-colombian music. The research reports were sent to the communities, to local, regional, and national state institutions, universities, researchers and NGOs interested in the groups studied.

Using a hermeneutic approach and individual and focus group interviews with key informants (shamans, midwives, community leaders, promotion health workers, mothers and nursing technicians), the nur-

sing research team sought to describe indigenous peoples' knowledge and health practices on children and adults; health characteristics of caregivers; and the pregnancy, labor, birth, postpartum and breastfeeding care (23).

Among the ecological and health problems found in the indigenous groups we visited were: Lack of adequate treatment of water supply, loss of natural resources, and crop fields; poor environment sanitation; risky customary practices with the umbilical stump; adaptation of foreign cultural patterns that changed traditional baby care practices, such increasing abandonment of breastfeeding; and lack of basic national health services, reflected in very low vaccination rates, and very high rates of epidemic diseases.

### Research and Intervention with Indigenous Peoples within a Participatory and Participatory Action Approach

Although there is increased interest among researchers in Colombia to participate in researches, studies with indigenous peoples are scarce. Among the documents reviewed, there is participation and action research studies conducted by anthropologists, interdisciplinary teams with local communities, and nurses. Through these studies, researchers have conducted community health diagnosis and have also developed booklets on traditional medicine, and educational materials for training indigenous health workers and non-indigenous health care providers. There are a few additional documents written by governmental and international organizations about ethno-development and policies for conducting research and health education with indigenous peoples.

Research conducted in Colombia on indigenous health, allows us to conclude that research studies on issues related to diversity and documentation of social injustices and unfairness are very limited. In the following section, I would bring attention to critical issues on indigenous peoples' health in Colombia including diversity, unfairness, and injustices.

### **Critical Issues of Indigenous Peoples' Health in Colombia: Diversities, Inequities, and Injustices**

In April 2007, an International Symposium on the Social Determinants of Indigenous Health was held in Adelaide, Australia. Participants of the meeting pointed key themes including self determination; ecology and environment; economic prosperity, fairness and equality; leadership and capacity strengthening; racism / dominance / imperialism; healing, services, systems, structures; cultural sustainability, protection, stewardship; land, and human rights. Based on the previous analysis and on a reorganization of the CSDH's themes, I identify five different and interrelated critical issues of indigenous peoples' health in Colombia. These issues

point to complexities and contradictions, and at the same time reveal unfairness and injustices:

- The land: Ownership, violence, and forced migration.
- Resources and environment: Poverty and possessions.
- Power: Self-determination and dependency-abuse.
- Identity: Discrimination and recognition
- Health Situation: Tradition and modernity

## **The Land: Ownership, Violence, and Forced Migration**

*What happens to poor people is never divorced from the actions of the powerful. Certainly, people who define themselves as poor may control their own destinies to some extent. But control of lives is related to control of land, systems of production, and the formal political and legal structures in which lives are enmeshed (24).*

The land is a critical resource for indigenous peoples around the world. For them, the meaning and value of nature and the land goes beyond its economic value; it is the sacred mother that provides food, medicines, water and whatever they need.

Spanish colonization in Colombia forced to move indigenous peoples away from the fertile and rich territories they inhabited before the 16<sup>th</sup> century, to marginal lands, in some cases unsuitable for agriculture. Paradoxically, these same lands are now used by drug traffickers, legal and illegal armies, development projects, and voracious enterprises of legal and illegal mining.

Since colonial times, indigenous peoples were “excluded from their right to private property” (25). After centuries of legal dispossession, indigenous peoples were recognized by the Colombian state in 1980 as the collective owners of the lands they inhabit. In 1991 the new Colombian Constitution represented a significant improvement: It assured the protection of ethnic and cultural diversity; supported the autonomy of indigenous groups and their own forms of government; asserted the protection of the commons lands and the indigenous ways of joint ownership; and assured the protection of natural resources (21).

However, as it happens with several laws in Colombia these principles doesn't really work. The continued internal armed conflict in Colombia has caused the displacement of millions of people since the 1950s. Since the 1990s internal forced migration has continued to rise; between 1997 and 2006, 2,537,703 people were displaced representing 5.9% of the national population. Of these internally displaced people in Colombia, 12% are indigenous (26). Compared to the national population and other ethnic groups, life threatening experiences and risks have been the main cause of change of residency for indigenous people (27). Displacement among Co-

lombian indigenous peoples has increased since 2005, and between 2006 and 2008 was higher than the non-indigenous groups (20).

Forced migration has significant negative impacts on individuals and communities. In addition to the loss of land and housing, it produces uprooting, disruption of social and cultural networks and creates marginalization, food insecurity, and the decline of health conditions. For previously vulnerable populations such as indigenous peoples, forced migration constitutes a catastrophe. The loss of their land, their social and cultural traditions causes deep emotional pain, that some of them currently living in Bogotá describe as a “demoralizing loss of self-worth”. In the urban environment, reality is no better, as people in the cities and health providers do not respect indigenous peoples’ spirituality, customs and their traditional medicine (28).

A recent report by *Doctors without Borders* (29) stated eight barriers to access health service for Colombians living in conflict zones, including indigenous peoples:

- *Stigmatization.* They are accused by health services for belonging to an armed group.
- *Fear.* People living in conflict zones prefer not to go to health services in order to avoid been seen by armed actors.
- *Distrust:* 10% of respondents did not trust the health workers, fear that they may be linked to any of the parties to the conflict.
- *Distance:* Most respondents reported having to travel between one and eight hours to see a doctor.
- *Lack of roads:* 42.5% of respondents used waterways to get to the doctor.
- *Transportation:* 38.9% cannot access health services because of lack of transportation.
- *Natural obstacles:* Colombian geography itself is important barrier to access health services.
- *Purchase of medicines:* Nearly a quarter of the persons surveyed reported not having money to pay for the consultation or buy medicines.

Whether they are living in conflict zones or have been displaced to the cities, indigenous peoples in Colombia are much more likely to face barriers to access health services, mental health problems, and increasing inequalities and social exclusion. Yet they are not passive subjects; research studies conducted in Bogotá and in Pereira document that they live close to one another and make use of solidarity and organization as strategies to overcome the new and harsh realities they face in the cities (28,30). In this sense, their traditions and social structures work as social capital that they use to survive in the cities.

## Resources and Environment: Poverty and Possessions

Indigenous peoples in Colombia live between poverty and possessions. Historically, they have been excluded from economic, social, and political opportunities (25). Based on economic, demographic, and health indicators, indigenous peoples are among the poorest in Colombia. Also, the provision of public services are lacked in their territories (21), and they are exposed to environmental degradation (31). Compared to non ethnic groups in Colombia, they have a younger population than their Colombian counterparts; 45% of them are under 15 years old. They also have infant mortality rates that are double and even triple compared to the national average. They also have lower live expectancy (32), lower education rates, and limited access to potable water and sewage systems as well as national health services.

At the same time, they own their communal land, they have traditional medicines, knowledge and practices to protect the environment, and inhabit lands that have recently been recognized as rich, because of its potential for mining and oil exploration.

## Power: Self-Determination and Abuse

The historical abuses and genocide against indigenous peoples initiated by Spaniards in the 16th century have continued in Colombia to the present day. The current situation of several groups is so extreme that several are endangered (33); the Colombian Constitutional Court asserts that out of the 102 groups, at least 34 are endangered. These groups were forced to slavery by the rubber industry (34), and continue to be exploited as prostitutes, forced soldiers for both the legal and illegal armies in Colombia, and as laborers by religious groups, intellectuals (35), and handcraft traders. Children have also been kidnapped to work as domestic servants.

Despite what is stated in the Colombian Constitution and in several laws to protect indigenous rights and self-determination, the genocide and exclusion stills goes on(36). They continue being victims of human rights violations (26,37), displaced away from their territories and attacked by all the armed actors in Colombia. Between 1998 and 2004, 855 indigenous peoples were murdered (26).

They are also stigmatized by health care providers as people with poor hygiene practices (38); some journalists and health care providers discriminate them by judging their health practices as awkward and dangerous. Some hegemonic health services don't respect their health systems and traditions and behave in authoritarian and restrictive ways with indigenous peoples (38).

However, abuse is not only practiced by non-indigenous peoples. Although most Colombian indigenous communities have practices that protect women, children and older adults, some communities still use female

circumcision and stocks as punishment for girls (39, 40). In some communities girls under the age of five have higher rates of mortality than boys (32).

## Identity: Discrimination and Recognition

In the Colombian context, being and being called *indio* (indigenous) has different and contradictory meanings:

- For anthropologists, indigenous peoples have been one of their main focus of interest, having different meanings depending on the anthropologist's ideological or academic perspective: Ethnic diversity; exotic and special peoples; minorities who live in the margins of Colombian society; endangered populations that need to be protected, and autonomous people (41-43).
- Even though racism is not always recognized by Colombians as a national issue, it is expressed in daily life practices such as using the terms *indio* and *negro* as insults.
- Since the 1990s being *indígena* (indigenous), and being recognized as *indígena* by the state entails free access to health care, education and other public services. In such inequitable country as Colombia with more than 45% of the population living below the poverty line, obtaining these free services is certainly a privilege that many, who would like to identify themselves as indigenous, wish. In this context, the definition of who is and who is not indigenous has become an issue (44).

As the result of the 1991 Constitution and the 1993 health care reform, indigenous peoples came to be recognized as worthy of specific health policies that seek to ensure free health insurance, their participation in the development of health care plans and the adaptation of health services to suit the diversity of their communities. In this context, participation and intercultural matters are generally recognized by the institutions (governmental, NGOs and international) as conditions for the provision of health care services to indigenous peoples. A recent analysis points out that belonging to an indigenous group has a positive effect on the probability of accessing the national subsidized health insurance system (25).

However, discrimination and social exclusion related to health are common realities experienced by indigenous peoples in rural and urban areas. A study conducted with the Nasas, an indigenous group, concluded that despite high coverage by the national health system and their knowledge and use of traditional medicine, the Nasas had a precarious health situation characterized by bad sanitary conditions, and high inci-

dence of infectious diseases (45). A recent research study conducted with ethnic groups living in Bogotá about inequalities in access to health services, concluded that indigenous peoples, African-Colombians, and gypsies have to confront racial and ethnic discrimination, violation of rights violations, difficulties in accessing health services, and lack of recognition of their ethnic differences (38).

## Health Situation: Tradition and Modernity

*For the poor, wherever they live, there is, often enough, no health transition. In other words, wealthy citizens of “underdeveloped” nations (those countries that have not yet experienced their health transition) do not die young from infectious diseases; they die later and from the same diseases that claim similar populations in wealthy countries. In parts of Harlem, in contrast, death rates in certain age groups are as high as those in Bangladesh; in both places, the leading causes of death in young adults are infectious and violence (24).*

Until the 1990s there was very little systematic information about the indigenous communities' health in Colombia (46). Despite the fact that studies conducted between 1992-1993 by GHE researchers provided important demographic and morbidity data, there are few systematic studies about indigenous peoples. The information on indigenous health is disperse, and it is difficult to obtain specific data based on the ethnic background (47). However, all sources agree in affirming that the health situation of indigenous communities in Colombia is critical (48).

The health profile of a high proportion of indigenous peoples in Colombia is characterized by Diseases related to the geographical area they inhabit, poverty, and precarious living conditions. For instance, they are exposed to many infectious Diseases such as multiple intestinal parasitic infections, acute diarrheal disease, acute respiratory infection, tuberculosis, hepatitis B, and malaria as well as to malnutrition (31, 48-52). As with other indigenous communities in the world (53), they are victims at the same time by the so called *modern* diseases such as obesity, hypertension and diabetes that are affecting particularly indigenous peoples living in urban areas (38). Along with their exposure to modernization and acculturation, living conditions and realities have changed, for indigenous peoples. This has meant both improving their health situation through access to national health services as well as a decline in their health status, related to acculturation and loss of traditional practices such as breastfeeding (23). The rise of alcoholism and mental health problems have been also explained by modernization and loss of their cultural elements (48).

## Concluding Thoughts

In the midst of all these complex and critical realities, I think it is necessary “to think globally, act locally” (24). It also means thinking about and acting upon the social structures and interact with the persons in a local context. Like all of us, indigenous peoples are subjects and social actors in society; this means, they are subjects of social and cultural forces and agents who are able to build and transform their realities.

I don't have answers or solutions for the sufferings, challenges and unfair realities that many indigenous peoples deal with in daily life, but I think that research is a useful tool to unveil and reduce the unequal distribution of power, resources and money. In this context, some closing thoughts include:

- Globally, it is necessary to work on the four interrelated areas recommended by the World Health Organization: “(1) Global factors and processes that affect health equality; (2) structures and processes that differentially affect people's chances to be healthy within a given society; (3) health system factors that affect health equality; and (4) policy interventions to reduce health inequality, that is able to influence (1)-(3) positively, for example by identifying policy and program interventions with the potential to reduce inequalities in health and health services' purpose and opportunities to transfer the research breakthroughs to potential users with maximum effectiveness” (54).
- Locally: focusing on research studies that describes diversities of health systems and diseases' documents while it unveils inequalities and the social (economic) determinants of health. A particular challenge lies in the need to analyze internal inequalities, discriminatory and abusive practices within indigenous communities against children and women.
- Analyzing with colleagues, students and health care providers benefits and limitations of the cultural competence model, focusing on the risks of using it as a tool of homogenization and discrimination. In the North American nursing context, cultural competence is recognized as an important skill that health care workers should have in order to provide services of good quality to diverse ethnic groups (55, 56) and I do agree with its value and importance. However, it is important to take into account that even though culture and personality are closely related, they are not the same. Nurses and health care providers take care of persons within cultural contexts, we don't work with cultures as isolated or independent domains. Anthropologists have pointed out at least two other major problems of the model: First, it is based on a “static, reified, essentialist understanding of *culture*” (57), and second, “acting unquestioningly upon what one thinks one “knows” about



a particular culture in one's interactions with an individual is a racist behavior" (58).

- Developing participation and participative action research studies that, at the same time as they listen to indigenous peoples' voices and reveals inequalities and injustices, they train and empower people in the communities on the use of research as a means for developing relevant social policies and as a tool to negotiate with policy makers.
- Follow strict ethics protocols and guidelines, based on reciprocity and inclusion that respect their different views, their vulnerability, and their economic, social, and cultural rights. Applied respectfully and following international ethical standards, research can be a kindly and useful tool to promote equality, autonomy and self-determination among indigenous peoples. Yet it is necessary that as educators and health care providers be aware about the role we play in promoting power control, discrimination and stereotypes.

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