TOWARDS THE DEVELOPMENT OF SUSTAINABLE INDIGENOUS HEALTH POLICY: INSIGHTS FROM A COMMUNITY-BASED ASSESSMENT OF PRIORITY HEALTH CONCERNS IN THE COLOMBIAN AMAZON

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ABSTRACT

Indigenous groups in various areas of the world face major barriers to access high quality healthcare and health promotion services due to various geographic, financial, and cultural factors. Increased participation of indigenous peoples in healthcare and public health planning and policy is critical to decrease health disparity. Epidemiological data suggest that major health threats for indigenous peoples living in tropical environments include basic sanitation, perinatal diseases, and transmissible diseases such as malaria, respiratory, and gastrointestinal infections. However, the provision of adequate healthcare and health promotion services to address these issues is often challenged, not only by indigenous peoples' characteristics, but also by the characteristics of extrinsic factors, including health policy and providers' levels of cultural competency. This paper uses the "vulnerability model" to understand how the confluence of community and external factors places this population at higher risks than other underserved groups. A case study of three rural indigenous villages in the Colombian Amazon is used to illustrate the challenges and opportunities offered by the use of a Community Based Participatory Action Research (CBPAR) approach to identify and address priority health issues in a culturally inclusive and competent manner. Preliminary results from a community assessment of perceived barriers to access healthcare, major health concerns, proposed health promotion strategies and use of traditional medicine are presented from a community perspective. Implications for international health policy affecting indigenous peoples and other underserved groups are discussed.

INTRODUCTION

- "Underlying causes of poor health for indigenous people include colonization, homelessness, poor housing, poverty, lack of reproductive health rights, domestic violence and addiction. Healthcare should be envisaged from an indigenous perspective, which encompasses mental, physical and spiritual health."
  (UN Permanent Forum for Indigenous Issues, 2004)
- "Native American communities are strongly supportive of Community-Based Participtory Research (CBPR) and express less enthusiasm for research processes that are not based on participatory practices."
  (Burhansstipanov, Christopher & Schumacher, 2005)

PURPOSE

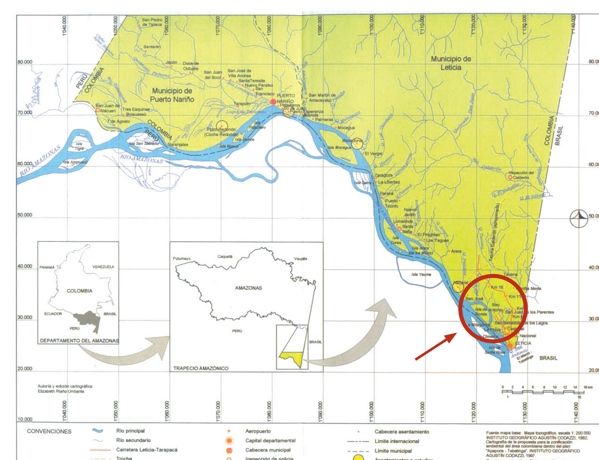
- This project supports the development of rural indigenous health partnerships with the objective of testing the effectiveness of the Community Based Participatory Action Research (CBPAR) approach to address indigenous health issues in the Colombian Amazon.
- Using a cultural and contextual adaptation of the CBPAR approach used by Project EXPORT in rural Illinois Hispanic communities, results from this project will allow for an exploratory comparison between the Illinois and the Colombian experiences in the use of partnerships and participatory approaches to address rural minority health and health disparity issues.

COMMUNITY-BASED PARTICIPATORY ACTION RESEARCH (CBPAR)

- Blend of Participatory Action Research (Fals-Borda, 1979, 1987) and Community Based Participatory Research (Israel et al., 2003)
- We conceive of CBPAR as a process that starts with the formation of a partnership and the subsequent cyclic occurrence of the four phases illustrated in the spiral figure.
- CBPAR adaptation to local culture and language

CBPAR Phase		*Spanish*	*Translation*
Partnership Formation	➔	***Unirse***	*Get together*
Assessment	➔	***Conocer***	*Know*
Implementation	➔	***Hacer***	*Do*
Evaluation	➔	***Pensar***	*Think*
Dissemination	➔	***Contar***	*Tell*

RESEARCH LOCATION



BACKGROUND: COLOMBIAN AMAZON

- **Population**
  - 81,487 residents (58.25% indigenous)
  - 27 different ethnic groups, predominantly Tikuna and Uitoto
  - 60.56% of the population lives in rural areas
  - 68.7 years of life expectancy
- **Epidemiological health information**
  - Major **mortality** causes in 1998:
    - Transmissible diseases (24.8%)
    - Violence (22.8%)
    - Perinatal problems (20.9%)
  - Major **morbidity** causes in 2006:
    - Acute Respiratory Infection (9,177 cases)
    - Acute Gastrointestinal Disease (5,426)
    - Bacterial Vaginosis (1,771)
  - Diseases with **largest percent change** between 2004 and 2006:
    - Malaria Falciparum (from 12 to 90 cases or 650%)
    - Hepatitis B (from 0 to 4 cases or 400%)
    - Mixed Malaria (from 3 to 8 cases or 166%)

  Source: Amazon State Secretary of Health
- **Potential causes for indigenous health disparity in the Colombian Amazon**
  - Cultural (e.g. traditional practices)
  - Community (e.g. poverty; CHW's skills)
  - Environmental (e.g. exposure to ID vectors)
  - Institutional (e.g. limited funding)
  - Health System (e.g. limited health workforce)
  - Historical (e.g. colonization)
- **Policy framework: General System of Social Security in Health (Colombian Law 100 of 1993)**
  - Decentralized: State and Municipal Secretaries of Health are in charge of basic prevention and control
  - More emphasis on prevention and primary care (Basic Primary Care Plan or PAB)
  - Privatization of healthcare (Health Promotion Organizations or EPS; and Healthcare Providers Institutions or IPS)
  - Regional Associations of Indigenous Authorities (AATIs) are expected to be in charge of their own health through creating their own or hiring external EPS and IPS services.
  - AATIs need capacity building on how to assess community health needs and build comprehensive, lawful and culturally-competent community health plans

VULNERABILITY MODEL (Shi & Stevens, 2005)

- In rural communities, health disparities have adverse effects not only on the underserved communities but also on governmental, non-governmental, health care and educational institutions, among others.
- Negative impacts are related to access/navigational issues in the health care system (System)
- Susceptibility to risk factors aligned to cultural background (Individual)

RESEARCH QUESTION(S)

- Is the use of CBPAR by a local partnership an effective strategy to identify and address health disparity issues in the context of rural indigenous communities in Latin America?
- What are the main health needs, risk factors, perceived barriers to access healthcare, and preferred health education interventions for indigenous people living in the rural Amazon? (Assessment)

PREPARATION

- Recruitment and training of a field coordinator with a social sciences background (Gómez) in the spring of 2006

  ↓
- Environmental scan of the zone in the fall of 2006
  - Inventory of institutions and resources
  - Inventory of studies and epidemiological data on indigenous health

  ↓
- Windshield tour in coordination with the Regional Association of Indigenous Authorities (AZCAITA) in six pre-selected communities in the spring of 2007

  ↓
- Final selection of three communities to conduct pilot project in the summer of 2007

Community Name	Population
San Sebastián	454
San Antonio	382
San Juan	91

PRELIMINARY RESULTS

Partnership formation *(Unirse)*

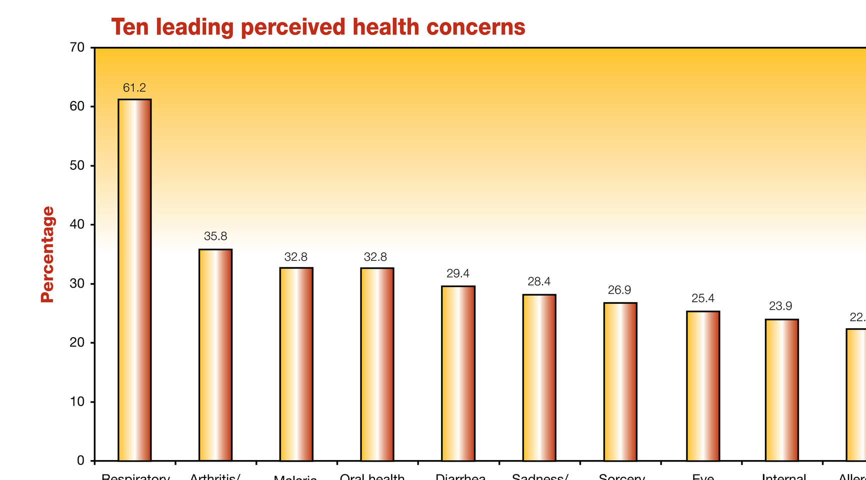
- Trust-building activities
- Community maps and kinship networks
- Local Health Committees' composition

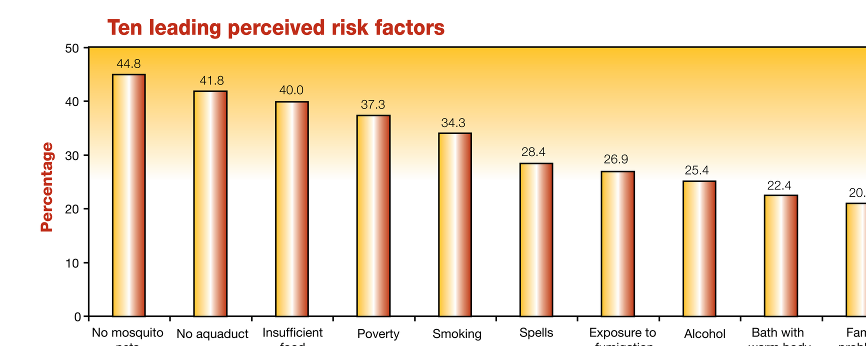
	San Sebastián	San Juan	San Antonio	TOTAL
Political leaders	3	2	2	7
Health promoters	2	1	3	6
Midwives	4	-	1	5
Youth	2	1	2	5
Traditional doctors/ herbalists	3	-	1	4
Teachers	1	-	2	3
Farmers	2	1	-	3
Seniors	2	1	-	3
TOTAL	**19**	**6**	**11**	**36**

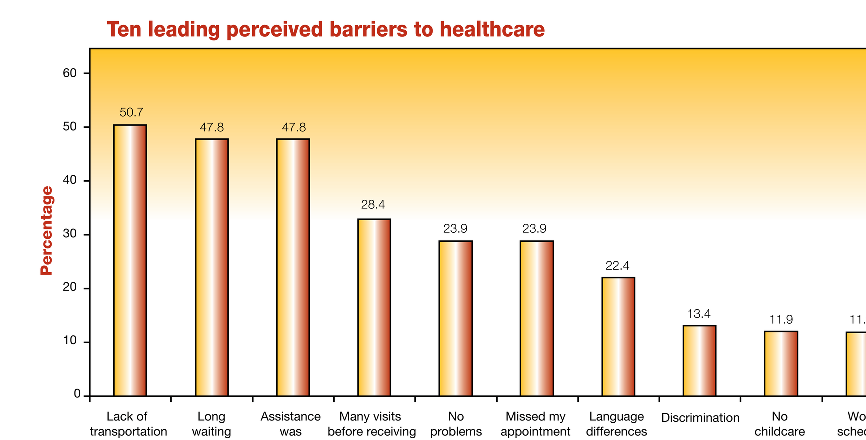
Assessment *(Conocer)*

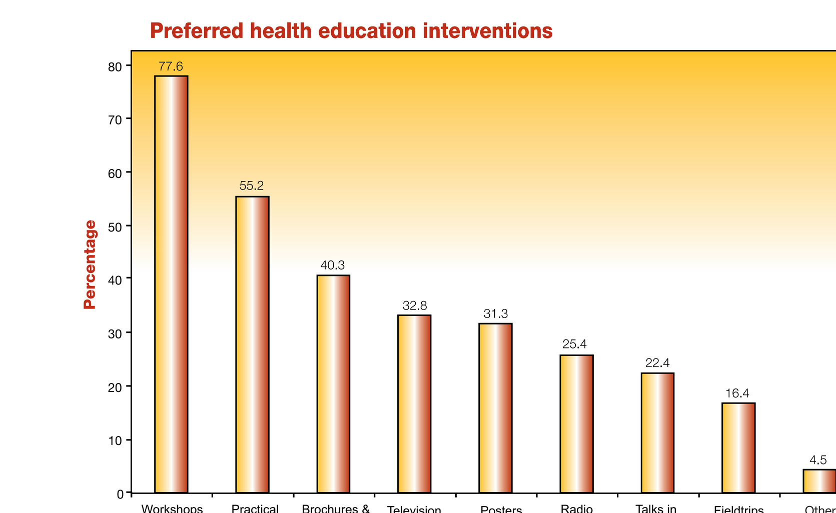
- Traditional epidemiological calendars
  - Gastrointestinal and respiratory infection occur between Feb-Apr when:
    - River flooding levels increase
    - There is high precipitation (rainy season)
    - There is *Chontaduro, Caimo, Aguaje, Copoazu* and *Asai* Harvests
    - There is abundance of *Sardines* and *Palometas* for fishing
  - Malaria occurs between Aug-Oct when:
    - River flooding levels decrease
    - There is little precipitation (summer season)
    - There is *Pineapple* Harvest
    - There is abundance of *Bocachico* and *Lisa* for fishing

- Community assessment survey
  - Participants
    - Adult residents sample from two of three selected communities (one community withdrew from the study)
  - Instrument
    - Community Health Needs Assessment instrument previously used by EXPORT in Illinois was culturally and linguistically adapted
    - Local committees reviewed various instrument drafts and provided feedback
    - Instrument was pilot-tested with six committee members and its final version approved by all the committees involved
    - Final version (17th draft) consisted of a 39-item paper-based questionnaire:
      - Perceived health concerns
      - Risk factors
      - Illness attributions
      - Barriers to healthcare access and use
      - Traditional medicine
      - Acculturation
      - Social networks of health knowledge transmission
      - Health education and promotion preferences
  - Procedure
    - Data collection is taking place through community events and household visits
    - Partnership with "San Juan Bosco" Indigenous Board School. Research course for 11th and 12th grades
  - Preliminary Results (n=67)
    - San Juan (n=38); 84.4% of the adult population
    - San Antonio (n=27); 20.4% (ongoing)



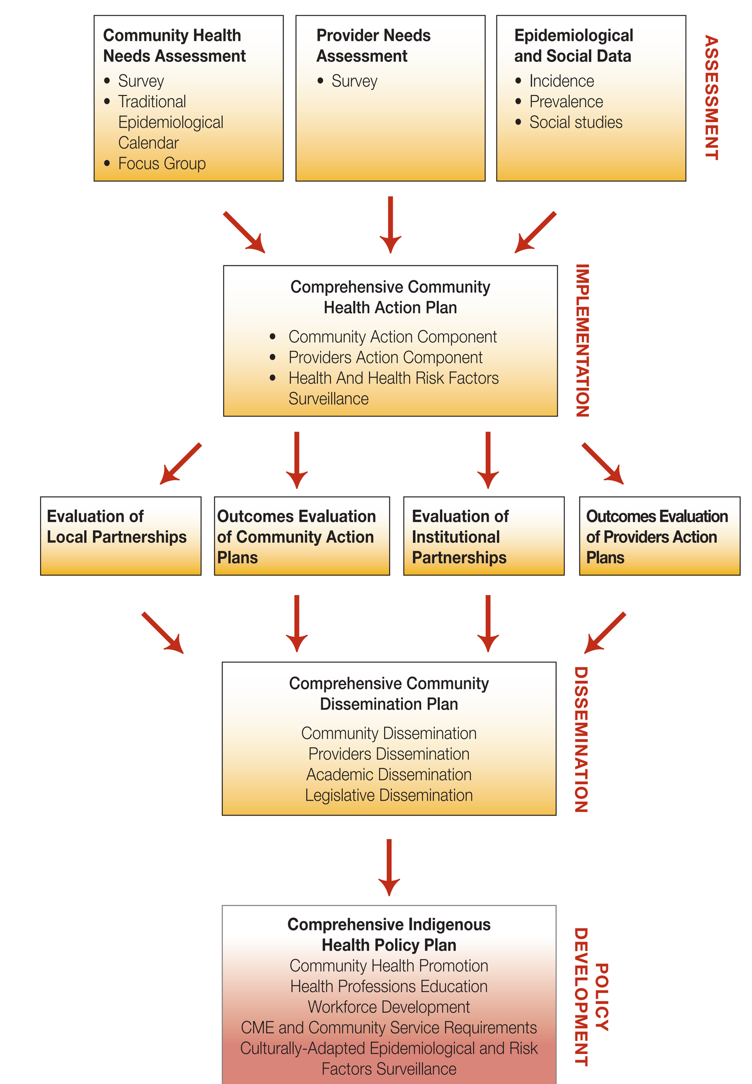






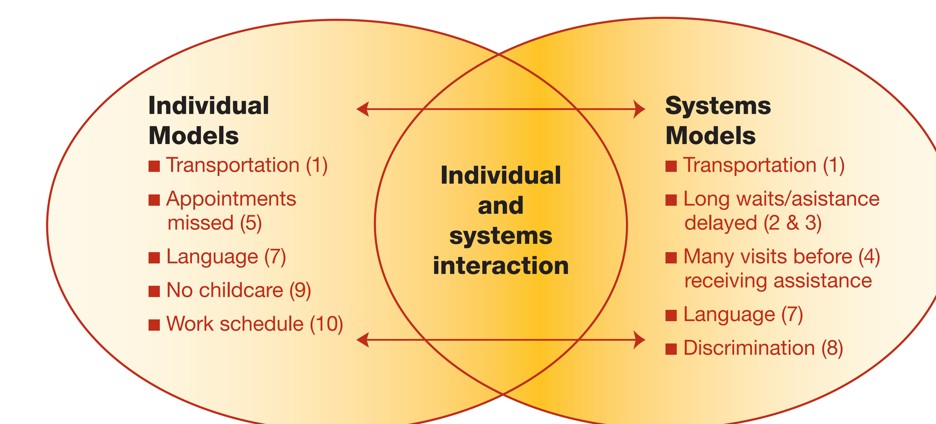
- Collaborative Efforts
  - Amazon Secretary of Health
  - AZCAITA (Regional Association of Indigenous Communities of the Amazon Trapezoid)
  - CODEBA (Indigenous NGO that facilitates the development of community "Life Plans")
  - ICBF (Colombian Institute of Family Well-being)
  - GAIA (NGO that works on indigenous education, health and self-governance)
  - HYLEA (NGO that worked on indigenous health in the Miriti-Parana region)
  - Leticia Municipal Secretary of Health
  - National University of Colombia, Leticia Branch
  - San Juan Bosco Indigenous Board School
  - San Rafael Regional Hospital of Leticia
  - SelvaSalud (Indigenous health promotion organization)
  - SINCHI (Amazon Research Institute)

NEXT STEPS



DISCUSSION

- The use of CBPAR in the simplified, culturally-adapted version presented here seems to be an effective tool for engaging communities in the development of indigenous health policy
- High levels of interest in the partnerships' work was expressed by committee members, communities, and external actors
- By participating in this CBPAR pilot study, partnerships have built their capacity to coordinate efforts and conduct community health needs assessments
- Potential for an institutional partnership to support local partnerships is growing
- Traditional epidemiological calendars provide us with crucial, culturally grounded information regarding the occurrence of diseases that are relevant to indigenous communities and their association with ecological variations throughout the year
- Preliminary identification of:
  - Respiratory infections, arthritis, malaria and major health concerns for participating indigenous communities
  - No mosquito nets, no aquaduct and insufficient food as major risk factors
  - Workshops in the community, practical workshops and brochures/booklets with drawings as preferred health education strategies
  - Lack of transportation, long waiting time and several visits to healthcare providers before receiving effective assistance as major barriers to access healthcare
- Vulnerability Model of perceived access barriers for rural indigenous communities



ACKNOWLEDGMENTS

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- National Center for Rural Health Professions at the University of Illinois College of Medicine at Rockford
- ICAHN - Illinois Critical Access Hospital Network