

# Indigenous peoples of South America – inequalities in mental health care

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Introduction	185	The South American countries' response	187
Poverty and social exclusion	185	Traditional mental health resources – the future	188
Indigenous peoples' poor health	186	References	189

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## INTRODUCTION

The scarcity of information and psychiatric research for the South American region is alarming (Seale *et al.*, 2002). Although there are pioneering studies of psychiatric disorders using conventional instruments (see Chapter 20), these do not always ensure validity across cultures; for example, there is very little information on indigenous illness categories or indigenous healing practices. According to reports from the 1970s and 1980s, comprehensive mental health services are lacking in Latin America and often have the lowest priority both politically and socially (Argandoña and Kiev, 1972; Alarcon, 1986). A transition now under way in these countries involves a move away from the use of large urban psychiatric hospitals towards establishing psychiatric beds in general hospitals, and ultimately towards the integration of mental health care with primary health care (Murthy, 1998; Larrobla and Botega, 2001; Saldivia *et al.*, 2004). The process of restructuring psychiatric care in South America began in the 1980s and escalated during the 1990s. Although these structural developments in mental health care are laudable, they neglect the mental health care needs of the indigenous peoples of South America. In the context of limited resources,

resource-starved mental health services, and social indifference to the mentally ill, it is ironic to attempt to describe South American mental health services for the indigenous peoples.

The fact is that 30 million indigenous people in South America, forming up to 10 per cent of the general population, live in outrageous conditions of human misery and neglect. Conventional Western-type mental health care for them is just non-existent. This chapter adopts a specific way of documenting the mental health status of indigenous peoples by reviewing some of the socio-economic and health indicators of this forgotten and voiceless people.

## POVERTY AND SOCIAL EXCLUSION

Poverty and social exclusion plague the indigenous peoples of the Americas. Many international organizations, including the Pan American Health Organization (PAHO), the United Nations (UN), the World Bank, and the Inter-American Development Bank, among others, have produced numerous technical reports revealing their misery. What is striking is the consistently higher poverty rates (defined as living on US\$2 per day or less)

found among the indigenous population. In some South American countries, the poverty rates are three to four times the national average. There is a clear-cut geographical distribution of misery in South America. The highest rates of poverty and extreme poverty are found precisely in regions with the highest indexes of indigenous population (Psacharopoulos and Patrinos, 1994). A strong poverty–ethnicity correlation exists in rural and urban areas among different countries of the region. The World Bank’s 1995 poverty assessment for Ecuador, for instance, found that households in which an indigenous language is spoken are more likely to be poor than are Spanish-speaking households, and strongly indigenous populated regions are worse off with respect to social and service variables, such as education, nutrition, housing, water and sewerage. In areas with an indigenous population majority, the poverty rate (including those highly vulnerable to poverty) is approximately 85 per cent (Van Nieuwkoop and Uquillas, 2000). Latin America in general and South America in particular demonstrates the greatest disparities in income as well as other socio-economic determinants of health in the world (Pan American Health Organization, 1999). Brazil has the highest income disparity in the world, and in some countries, the richest 10 per cent of the population receive 84 times the income received by the poorest (Duncan *et al.*, 1995). Table 19.1 shows some details of the estimated indigenous population in several countries of South America.

The United Nations, in its World Population Prospects for 1998, noted the dramatic nature of the socio-economic conditions of South America’s indigenous peoples. Recently, the United Nations Economic Commission for Latin America and the Caribbean confirmed their deplorable status of being the poorest among the poor. Fortunately, in the last couple of years, the word is spreading publicly. Nils Kastberg, UNICEF’s Regional Director for Latin America and the Caribbean, said at the Foro Iberoamericano sobre la Niñez, held in Madrid in 2005: ‘in Latin America, discrimination is a structural problem, between 88% to 95% of the Indigenous Peoples continue to live in exclusion.’

In this continental context of extreme socio-economic inequality, we can expect dramatic health

**Table 19.1** *Estimated indigenous population in South America countries and selected territories (by millions of inhabitants)*

Country	National population	Indigenous population	Per cent
Bolivia	6.9	4.9	71
Peru	20.0	9.3	47
Ecuador	9.5	4.1	43
French Guiana	0.1	0.004	4
Paraguay	3.5	0.10	3
Colombia	30.0	0.60	2
Venezuela	18.0	0.40	2
Argentina	31.9	0.35	1
Brazil	140.0	0.3	0.20

Adapted to show data for South America.  
Source: Pan American Health Organization (1993).

and mental health service disparities. Moreover, often the indigenous peoples in South America are treated as outsiders and as inferiors (Cohen, 1999) and consequently they are literally excluded from the conventional Western mental health services.

## INDIGENOUS PEOPLES’ POOR HEALTH

The poor health status of the indigenous peoples of South America is believed to result from social exclusion, alienation of health and mental health services, genetic vulnerabilities and colonial oppression (Duran and Duran, 1995; Durie, 2003). The Pan American Health Organization Report on Health Disparities in Latin America and the Caribbean concludes that there are direct ties between the indigenous people, extreme poverty and disproportionately high mortality/morbidity rates (Pan American Health Organization, 1999).

Indigenous peoples generally have high mortality rates, lower life expectancy, malnutrition and higher incidence of most diseases than non-indigenous populations. The infant mortality among the Quichuas of northern Ecuador was 211 per 1000 in 1986, while the national average was 38. The infant mortality in the region is 2–3.5 times higher for the indigenous children. In Honduras,

life expectancy was 29 years lower for men and 27 years lower for women than the national average. A 1993/94 survey in Colombia found a life expectancy of 57.8 for women and 55.4 for men while the national average for the country was 67–65 years (Pan American Health Organization, 1999, p. 10). According to a 2004 Mission Report for the World Food Program in Guatemala, malnutrition affects 69.5 per cent of the indigenous population compared with 35.7 per cent in non-indigenous populations; in some areas this figure increases to 88 per cent (World Food Program, 2004). It is estimated that 95 per cent of indigenous people aged 14 years or less are malnourished.

We are going to close this section of health indicators by mentioning the consistent lack of basic public services such as water, sanitation, housing, electricity, etc. available for the indigenous communities (Van Nieuwkoop and Uquillas, 2000).

There is a scarcity of research on mental health among the indigenous peoples of South America. There is a very limited knowledge about the prevalence, incidence, risk factors and protective factors for mental disorders among this population (Seale *et al.*, 2002). We do not have mental health services data related to gender, the elderly, children, adolescents, migrants, displaced communities and other vulnerable groups.

## THE SOUTH AMERICAN COUNTRIES' RESPONSE

Following 180 years of independent life as nation-states, the countries of South America have done little or nothing for the wellbeing of the indigenous peoples. Only in 1978, the World Health Organization conference in Alma Ata, URSS proposed the implementation of primary care as a priority in which the indigenous medicine was mentioned for the first time 'with the support of formal health systems, the agents of Traditional Medicine can become important allies in organizing efforts to improve community health'. This proposal was welcomed with great enthusiasm by the Asian and African countries, but not by those in South America (Pan American Health

Organization, 1996). The official sources in most of the countries of the region have little or no information on the health status and living conditions of their indigenous peoples. Then, in 1995 the United Nations launched the International Decade of the World's Indigenous People (1995–2004), aimed at increasing international cooperation to tackle their human rights, environmental, educational and health problems (United Nations, 1994).

Other regional and continental meetings followed, such as the First Continental Meeting, Five Hundred Years of Indigenous Resistance, held in Quito, Ecuador in 1990; the Continental Campaign, 500 Years of Indigenous, Black, and Popular Resistance, held in Esteli, Nicaragua in 1992; and finally, the First Hemispheric Working Meeting on the Health of the Indigenous People, held in Winnipeg, Canada in 1993. Those efforts culminated with the approval of Resolution V at the XXXVII Meeting of the Directing Council of the PAHO, on 28 September 1993. Resolution V reflects the higher ranking political will of the member governments of the PAHO in promoting the Initiative on the Health of Indigenous Peoples of the Americas (Pan American Health Organization, 1993).

Despite the goodwill and high-profile signing of the PAHO Initiative by the member states, the follow-up of the programme is poor, and its impact on the health status and wellbeing of the members of the indigenous nations of South America has been hardly noticeable. PAHO has even created the Health of the Indigenous Peoples Unit. Several countries have created specific units that are meant to deal with indigenous peoples' health in general, with no mention of mental health.

One last, yet interesting workshop called 'Programas y Servicios de Salud Mental en Comunidades Indígenas' (Mental Health Programmes and Services for the Indigenous Communities) was held on 16–18 July 1998 in Santa Cruz city in Bolivia (Pan American Health Organization, 1998). The goal of this meeting, sponsored by PAHO and the Government of Bolivia, was to outline the basis for the implementation of mental health programmes and services for the indigenous peoples of the region. Many countries participated in this unique and small

workshop, including: Bolivia, Brazil, Chile, Ecuador, the USA, Guatemala, Mexico, Nicaragua, Peru and nine PAHO officials. Seven years later, however, no particular programmes of mental health designed for indigenous peoples exist in South America.

As recently stated by Health Unlimited (a British non-governmental organization) and the London School of Hygiene and Tropical Medicine, indigenous peoples are unable to access routine health care and are dying prematurely, despite efforts by the United Nations and PAHO, and their member states (Tayal, 2003). Although the above-mentioned initiatives are commendable, legitimate and full participation of indigenous peoples in controlling their own future remains contentious. Organizations such as PAHO, and regionally the ministries of health and mental health care services, remain hermetic and distant to the indigenous people. For example, the author himself was repeatedly unsuccessful in even getting an appointment to meet the Ecuador Representative of PAHO when attempting to invite PAHO to participate in the World Psychiatric Association's Transcultural Psychiatry Section Symposium entitled 'Psychiatrists and Healers: Unwitting Partners – A Challenge for Transcultural Psychiatry in Times of Globalization', held in Quito, Ecuador, in May 2005. The Runajambi – Institute for the Study of Quichua Culture and Health hosted this meeting.

To further put local human faces to this situation, in 1986, we were the first two Quichua physicians in Ecuador to graduate from the medical school in Quito. Today, almost 20 years later, there are five Quichua physicians for an estimated population of 5 million indigenous people in Ecuador. With this pace of change, the existing staff, the available psychiatric services, and the mental health of our communities will not improve in the foreseeable future.

## TRADITIONAL MENTAL HEALTH RESOURCES – THE FUTURE

The indigenous peoples view themselves as invisible, voiceless, dispossessed nations subdued by the nation-states of South America. The global

neglect and exploitation is viewed as the perpetuation of centuries-long colonial oppression. The lack of mental health services and the outrageous health disparities are interpreted as the consequence of their status of subjugated nations. Furthermore, it is striking to see how much conventional health care systems and professionals end up overlooking the extensive indigenous systems of health care that carry the trust of indigenous peoples.

Fortunately, a widespread traditional health and mental health care network exists within the indigenous peoples communities, composed of traditional healers, bonesetters, midwives, the community, families and elderly women. Traditional healers, of which there are tens of thousands, still enjoy high prestige in their communities, and they are often considered by indigenous patients to be their trusted doctors (Incayawar, 1995). According to the World Health Organization's World Mental Health Surveys, 75–85 per cent of the world population relies on local healers when in need of medical care (Demyttenaere *et al.*, 2004). At the same time, only a fraction of the world population has access to Western psychological and psychiatric services. In Ecuador, we have only one Quichua psychiatrist for 5 million indigenous people. If mainstream conventional services neglect the needs of these peoples, and there are insufficient numbers of Quichua psychiatrists, then the problems of indigenous peoples are clearly likely to be neglected for generations to come.

Indigenous peoples-led health institutions are proposing some alternative approaches. Although the majority of them are located in the USA and Canada (Aboriginal Healing Foundation, 2004; Royal Commission on Aboriginal Peoples, Canada, 1993; Walters *et al.*, 2002), there are at least two formal projects in South America that deserve attention. One is the Jambihuasi project in Otavalo, Ecuador, which was founded in 1984, with the support of Quichua professionals, Quichua healers, community leaders and a provincial political organization. Jambihuasi offers an integrated Western and Quichua medical service, and referral to medical specialists. The patients are free to choose the provider, either a traditional healer, a biomedically trained physician, or both. The levels of acceptance and satisfaction of this integrated

service by the Quichua patients and families is very good. Another project is Runajambi – Institute for the Study of Quichua Culture and Health, created in 1990, which was the first Quichua institution created in Ecuador. It is devoted to the betterment, through research, of the health of the indigenous peoples of the Andes. Runajambi promotes the collaboration of healers and doctors as the key element for achieving a good health for the Quichuas.

Traditional healers are helping to reduce the disparities in life expectancy and health among indigenous peoples of South America. As stated in the *World Health Report 2001 – Mental Health: New Understanding, New Hope* (World Health Organization, 2001), traditional healers could help in the global efforts to improve health through the following activities: (a) as active case finders; (b) facilitators of referrals; (c) providing counselling; monitoring and in the follow-up of cases. Their role is viewed as essential for increasing access, identification of psychiatric cases in the community (Incayawar, 2001) and successful treatment of psychiatric patients.

In closing, we can conclude that mental health care for indigenous peoples remains a low priority for health and social care agencies and local governments. From the indigenous perspective, global exclusion is a direct result of a policy of internal colonialism that has continued for centuries (see Chapters 2 and 5). The indigenous nations and their members are treated as second-class or vanquished individuals. In this context of consistent neglect throughout South America, the indigenous peoples remain encouraged by the active role of traditional medicine in the provision of health services but not by the plans and reports of the South American states and governments. Culturally insensitive mental health services, programmes designed without the participation of Amerindian people and experts, services that emphasize greater influence of Western-trained mental health professionals and expensive Western health service infrastructures, can only perpetuate the misery and suffering of the indigenous people. Our communities and organizations are proposing to take control of our own destiny, promoting self-determination, having our own voice, taking a legitimate place within the Western-dominated institutions, requesting a fair

sharing of allocation of funds, heightening the capacities of traditional health systems, overall, becoming less invisible and voiceless. This kind of socio-political transformation is important in helping to improve the health and mental health of the indigenous people of South America.

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