"Towards a Cultural understanding of Health"
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Keywords: Culture-Identity-originary populations-cultural minorities-participatory model-culture specific

Culture and *identity* are two important factors which influence health. Usually in Latin America, these factors are not taken in account at the moment of performing health planning or assistance. But the fact that they are not considered in prevention or healing practices does not mean they are not necessary.

Identity gives a person a referential framework of who he is, and how to understand things and move through the world. His culture was transmitted and taught from his first steps in life, and introjected to form part of his own background. His cosmogony extends to all life areas and builds up his relationships with the others and with his surrounding world. We can recognize an individual identity, which also has familiar, group, ethnic, etc. components.

As a citizen of his country, each person has the right of receiving an adequate health care, understanding by it, the health practices which correspond them not only in terms of medical issues, but which should also be culturally appropriate.
Health planning and practices should be culturally considered. In general, the Official Health System is thought in terms of western culture (scientific), what mates western populations, but not *cultural minorities.*

Orginary populations cosmogonies differ essentially from western point of view, as originary thought is circular and western thought is lineal. Also, originary cultures correspond to what is called "Integrative Cultures". Therefore, the concept and pratice of health integrates the earth, the environment, community, rituals, etc. Health is conceived for them as a wheel, which includes and articulates in a special way their cultural conceptions.

Being healthy means having a healthy mind, a healthy body, a healthy environment and a healthy community within a cultural framework.

While understanding health as a cultural matter, it is basic that *cultural minorities* health plans should not designed by an official majority. It is necessary to develop *participatory models* to apply to users whose needs are different or exceed the official ones.

Participatory models of health should include not only persons, but also *culture-specific* tools for the design of health policies and the healing practices as well.

Participatory models for Health Planning help to detect community problems, as their causes; help to design campaigns and preventive actions, which come from "the heart" of the community and go direct into it. Then, in the development of the health action, as in its evaluation, there should be included specific culture workers.

Participatory Background

By XIX century America had been definitively colonized by England and France in the North, and by Spain and Portugal in Centre and South.

Native populations existing at the moment of conquest had their own cosmogonies, and health systems. The nature of those health systems was basically shamanic, understanding by shaman a special curer who can also contact the spiritual world for his healing act. Healing was performed in ceremonies, sometimes with the presence of community and rituals for curative purposes were developed. Therefore, healing was not a single or isolated act, but it was a very highly symbolic and participative core.

Diagnostic methods and treatments included the combination of plants, minerals or animals, used in special ways, determined by the curer s knowledge, and diagnosis themselves reflexed their cosmogonies.

Colonization brought with itself not only new people and culture, but also a neglect of the original ones, in America.
The usual languages spoken among peoples were forbidden, as most of their cultures and cultural practices, including healing.

The cultural loss and fragmentation were traumatic in themselves, and one of its consequences was that the originary peoples had their medical systems no more.

The originary medical and health systems were replaced, then, for western medicine, which was absolutely different to the previous one, but was installed as official.

Thus, originary peoples were forced to adscribe to the new and european medicine, as a part of the whole they had to adscribe.

The time passed, and in the last years, the originary peoples started recuperating their ancestral cultures. This recuperation was done by story telling, by elders, what permitted bring back oral history as an identity and cultural issue. There is taking place, also, some land recuperation, and health plans designed by native are being developed, in countries like Canada. At the NAHO (National Aboriginal Health Organization) journal, the "Journal of Aboriginal Health" (1) there s an article called "From woundedness to resilience: a critical review from an aboriginal perspective". This paper gives the idea of a "trip", a "healing journey" starting at the past and going onto the future.
In this article, among other concepts, the authors make reference to the learning from a collective grief. It is not only learning from the past in terms of culture recovery, but also learning from a collective grief.

It is important, as it is shown, to share knowledge, for building up a pertinent health framework, but it is also necessary to share the recovering voices messages.

Participation is part of the process, as it wouldnt be possible to reconstruct what suffered fragmentation, without native peoples participation themselves. It is for them that has a sense, and it is from them that it is really understood. The elders memories do not sound strange to the new generations, but seem to evoque a "genetic memory" by which the story telling makes sense in a present time.

Participatory Planning

It is impossible to go backwards to the point of turning everything as it was. And it is not a good idea to leave health in the hands of western culture only. It is, therefore the interrelation between ancient and western cultures the one that can give an answer to the originary peoples needs.

This interrelation may have different aspects: on one side, all what is so-called "Intercultural Health", which usually referrs to assistance. But it is necessary that the heath planning develops participatorily too. The official Ministeries of Health may detect what health issues are important to take care of. But they should dedicate a part of its money to enhance aboriginals health level by combining official research tools and native ones.
The NAHO has three centres which are dedicated to health planning: The Ajunnging Centre, for the Inuit, the First Nations Centre, and the Metis Centre. Each of them work in its *culture specific* Health Plans, for peoples living in reserves and also for urban originary peoples.
These centres take in account illnesses of western diagnosis which affect native populations, as Diabetes, Fetal Alcoholic Withdrawal Syndrome, etc. and create native assistance and preventive models.

In Ottawa there exists the Wabano Centre, dedicated to healing of urban native peoples.
Its program includes not only actions for known syndromes, but spiritual healing, as it could be promoted by drumming (ritual) (there is a drumming group for women) or sweat lodge.

At Montreal exists the CINE (Centre for Indigenous Nutrition and Environment) from Mc Gill University, and which, among other tasks, has developed a model for "Indigenous Peoples Participatory Health Research. Planning and Management / Preparing Research Agreements", which was cursed to WHO. This Centre was created in 1992 in response to the needs of Canadian First Nations, who were claiming for participatory research in relation to their food,and health, and works conjunctively with The Assembly of First Nations, Council of Yukon First Nations, Inuit Circumpolar Conference and other institutions of the Originary Peoples, Metis and Inuit. It is an interdisciplinary centre located at the Macdonald Campus in the Faculty of Agricultural and Environmental Sciences, Montreal.

At the University of Manitoba, at the CAHR (Centre for Aboriginal Health Research) and at the Faculty of Human Ecology, there are developed international research and intervention programs, which include participation of native peoples.

I would like to introduce a new centre, Centro de Etnosalud, product of six years of work between Dr. Javier Mignone (Canada) and Dr. Valentina Farias (Argentina), and of the signature of a Memorandum of Understanding between the University of Manitoba, Canada, and the University FASTA, Argentina (universities of both of them). The centre is based in the last one, and a ONG is being planned, to have a base directly in community, too.
The Centro de Etnosalud (Centre for Ethnohealth) is dedicated to teaching, research and intervention in the health of originary peoples and migrants. Its geographical extension for working is centered in the argentine Patagonia, but it can work through all America.
The Centro de Etnosalud is making its first steps, and goes in the direction of promoting *participatory and culture specific actions* for the welfare of cultural minoritarian populations, working in interdiscipline and with cultural communities. The two areas of the centre are: Ethnohealth and Trasncultural Psy (psychology, psychiatry).

In a very interesting paper called "Community Health for First Nations: Connections to Biodiversity" (2) there is a figure integrating a western "indicator of health" and an indigenous "health and life indicator". The Western Disease Indicator show Suicide Rates among young people in First Nations (which is high), the traditional Life Indicator shows the youth participation in Traditional Ceremonies. The integration of the two concepts shows: Relationship between the number of drums in a community, ceremonies where drumming groups participate and the effect this has on Suicide Rates among young people.
This is a very clear example of how western detection of illnesses combined to native indicators can give place to an understanding of fault of health, culture specific and which can give place to real and adequate solutions.

The Centro de Etnosalud is paying special attention to the development of Non- Transmissible Illnesses (diabetes type 2, hypertension, high cholesterol rates, etc.) in rural communities. Traditional food was replaced by bad samples of western food, sedentarism was introduced and transcultural stress accompanies the process. An integrated indicator in this case, could be the relationship between traditional food eating, traditional activities displayed and non-transmisible illnesses.

Final Words

It may sound strange for the ones used to the official health systems to consider the patients culture and point of view for health planning, but evidence shows that if not taken in account, cure fails to give the expected results.

References:

(1) Lavallee, Barry; Clearsky, Lorne : "From woundness to reliance: a critical view from aboriginal perspective". Journal of Aboriginal Health, Sept 2006. Vol 3, Issue 1, Published by the NAHO.

(2) Leech, David; Lickers, Henry and Haas, George: "Community Health for First Nations: Connections to Biodiversity", Biodiversity, Journal of life on Earth, Vol. 3 Number 3 Aug. 2002, Knowledge, Conservation, Sustainability.