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Commentary

Intercultural Bridges: Reflections on Navigating Both Sides

Comment on "Routes of Well-Being, Spiritual Harmony and Recovery in Mental Health: The Community as a Policy-Maker"

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Abstract

The mental health of Indigenous populations in Latin America is a public health issue that has received little attention, which serves to perpetuate discrimination against these peoples. Governments address these gaps and work to reduce health inequalities through public policy and an intercultural approach. Interculturalism generally acknowledges cultural differences but fails to address the root causes of inequality—namely, social structures underpinned by ideologies of discrimination and racism, which have historically relegated Indigenous populations to the lowest levels of the social structure. The concept of "intercultural bridges" is invoked to illustrate the scope of the classical perspective on interculturality and, ultimately, to reflect on the extent to which integrating the traditional medicine model with the Western biomedical model can promote the well-being of these populations.

Keywords: Critical Interculturality, Traditional Medicine, Western Medicine, Structures of Inequality

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Mental health, particularly among disadvantaged populations, such as those living in poverty, Indigenous communities, or migrants, has received less attention in public health research than other health issues. There is very little information available that can shed light on the mental health conditions of these populations, and from an intersectional perspective,[1] this represents yet another layer of vulnerability.[2] The lack of strategies and actions aimed at addressing the mental health needs of these populations reflects the social inequalities responsible for health gaps. The absence and/or lack of specific data and statistics is another form of discrimination against vulnerable populations.

The article "Routes of Well-Being, Spiritual Harmony, and Recovery in Mental Health: The Community as a Policy-Maker"[3] draws attention to this "broad" issue of mental health among Colombia's Indigenous population. But it also addresses another social problem related to this population's lack of participation in the design of public policies and government decision-making. We could say that this is a common situation in several Latin American countries, which, like Colombia, are characterized by multiculturalism and ethnic pluriculturalism within their territories. The general population, and vulnerable populations in particular, remain largely excluded from this arena due to a lack of opportunities, rather than a lack of interest.

The exercise of their rights, including the right to receive health care, is not a practice assumed by these marginalized populations, in part because constant social exclusion leads them to not view themselves as subjects of law. Their voice, then, silenced by historical social mechanisms of discrimination and racism, learns to remain silent. That is why the participatory perspective adopted by the authors in the article "Routes of Well-Being, Spiritual Harmony and Recovery in Mental Health: The Community as a Policy-Maker"[3] is both relevant and necessary.

Public policy is one of the main tools available to governments to ensure that Indigenous peoples can fully exercise their rights[4] and address health disparities caused by the barriers to access to care faced by these populations; Developing participatory strategies and engaging in community consultation are two fundamental pillars that can guide the development of these policies. Since 1978, the Alma-Ata Declaration has recognized the importance of community participation in the field of health. This declaration stated that: "People have the right and the duty to participate, individually and collectively, in the planning and implementation of their health care (paragraph IV, page 1)."[5] So why have these participatory actions been an exception rather than the rule?

The intercultural perspective appears to have been key to promoting the participation and integration of Indigenous populations in these decision-making processes; however, the outcome depends on the underlying concept of interculturality.

In Latin American health systems, a vision of interculturality has prevailed that is based on the recognition

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of cultural differences between service users and health care providers, This recognition leads primarily to two things: (*a*) the (physical) adaptation of the spaces where health care is provided, especially in services located in regions with a higher concentration of Indigenous populations, including the involvement of interpreters or translators of indigenous languages, and (*b*) the proposal to integrate traditional medicine into the biomedical or Western model of care.[6,7]

However, recognizing these differences is a necessary but insufficient step toward overcoming the barriers the population faces in accessing and using available health services, because these barriers do not lie in the cultural sphere but rather stem from structural barriers generated by and within contexts of inequality.[8,9] For this reason, critical interculturalism, which recognizes the role of structures of inequality in addition to cultural differences, appears to be the most promising perspective.[10]

There have been many government initiatives, particularly in Latin America, aimed at encouraging the Indigenous population to make greater use of health services; some of these focus on identifying (and training) health promoters,[11] members of the communities themselves who are trained to provide primary care and serve as facilitators between the population and health services, and for this work, they have been called "intercultural bridges" a metaphorical reference to the role they play. However, what has happened in most cases is that these bridges are one-way, rather than two-way.

This metaphor is based on the definition of interculturality in health offered by Oyarce and Ibacache, who define it as "the ability to navigate in a balanced way among different cultural knowledge, beliefs, and practices regarding health and illness, life and death, and the biological, social, and relational aspects of the body. These perceptions can sometimes even be contradictory."[12]

However, this capacity for balanced mobility cannot occur in practice; theoretically, a bridge is a structure, in this case, a symbolic one, that is traversed in both directions, but health systems are typically organized around normative needs and rarely, very rarely, in fact, cross to the other side of the bridge to speak with the population, ask them about their perceptions of health and illness, about ways to pursue good health, and, above all, to understand their needs. That is why initiatives such as the one presented in this article represent, at least potentially, opportunities to truly move in both directions across intercultural bridges.

The study reported here is based on a qualitative approach and incorporated various quality criteria consistent with this design. This is valuable because many studies involving community members lack rigor, as if engaging with the population did not require seriousness and a systematic approach. Sometimes these approaches are carried out more spontaneously than planned, and although spontaneity is important, it does not replace the rigor of the method, which inherently also incorporates flexibility.

Qualitative studies bring people's perspectives to the forefront, and in the field of health, this is particularly necessary to guide actions and programs and ensure they are culturally relevant. Study participants highlight the importance of this aspect by identifying the lack of an intercultural perspective in mental health as a barrier to comprehensive care. And although it has been recognized that failing to integrate perceived needs into organized social responses constitutes a bioethical problem,[13] no clear strategies have been implemented to chart the path toward this integration.

Scope and Limitations of Integrating Traditional Medicine and the Biomedical Model

The voices of the participants in the study "Routes of Well-Being, Spiritual Harmony and Recovery in Mental Health: The Community as a Policy-Maker"[3] highlight the need for closer collaboration between Traditional medicine and Western medicine. This importance as perceived by the people becomes clear when we consider that, from their perspective on mental health, harmony and support networks play a fundamental role. However, this harmony is not necessarily replicated in their relationship with Western culture.

The fact is that building bridges is an effective strategy for bringing care services closer to the population and promoting participation, but this approach is not necessarily achieved through the integration of models. Healthcare experiences where both models have been integrated recreate historical relationships of subordination, such that the traditional medicine model ends up subsumed under the biomedical model[14]; representatives of both models have unequal participation because their social position is also unequal; and they do not promote the autonomy and empowerment of populations in a way that breaks the cycle of subordination. Social inequalities are reproduced in these strategies because they focus on highlighting (the benefits of) cultural differences but fail to address the structures of inequality; thus, poverty, lack of access to education, scarcity of economic resources and many other social determinants of health remain unaddressed. This reflects a recognition of multiculturalism, but not of inequality, so strategies such as this one have not been able to contribute to health equity.

As the authors point out in the limitations of their study, the challenge is determining who is responsible for implementing the path identified by the population, and who should lead comprehensive health projects. If the community takes the lead without considering the health system, it will face budgetary barriers; if the government leads them (as in the case of the study), the community is not empowered; thus, the article leads us to reflect on whether the integration of models is the path to achieving that state of well-being and spiritual harmony needed to restore the mental health that Indigenous populations long for, or should community participation be sought through other means? And finally, will the recognition of cultural differences, without transforming structures of inequality, have an impact on the health of these populations?

The integration of models (biomedical and traditional) has been a goal of public policies (on interculturalism) in several Latin American countries; however, this integration reflects a perspective that reduces actions solely to the recognition of cultural differences, without going beyond that. It does not transform people's living conditions – a necessary condition

for fulfilling the principle of horizontality required to cross the bridge from one side to the other. In my opinion, we should not insist on this integration, which feels forced given that the models have very different origins, purposes, and therapeutic approaches. It would be better to try to eliminate barriers to access to biomedical health services through coordinated, cross-sectoral efforts, so that people, when they so choose, can use them without obstacles (economic, cultural such as language, geographical); and so that they can also make use of traditional medicine, within the context in which it is practiced, if that is their preference.

If work with indigenous populations is based solely on the recognition of cultural differences, without identifying the social structures that create gaps and inequalities through practices of discrimination, racism, and classism, the health of these populations (including mental health) will not be improved, because it is not culture (language, identity) that causes illness, but rather poverty, a lack of safe drinking water, and food insecurity, among other factors.

These cultural bridges must necessarily be built in collaboration with communities and not solely by health institutions; thus, the changes identified to ensure that care is culturally relevant must consider the population's perspective. Until now, the so-called "intercultural" actions that have been implemented in health services (such as the vertical birthing chair) have reflected an *Ethic*[15] or external perspective. At the same time, addressing structures of inequality through cross-sectoral action is equally important.

Disclosure of artificial intelligence (AI) use

Not applicable.

Ethical issues

Not applicable.

Conflicts of interest

Author declares that she has no conflicts of interest.

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