Human resources for health with intercultural competency for the provision of health services to indigenous population in Peru

A literature review on policies, strategies and interventions in Peru

Fiorella Farje De la Torre
Peru

56th Master of Public Health/International Course in Health Development

KIT – Royal Tropical Institute
VU Vrije Universiteit Amsterdam

HUMAN RESOURCES FOR HEALTH WITH INTERCULTURAL COMPETENCY FOR THE PROVISION OF HEALTH SERVICES TO INDIGENOUS POPULATION IN PERU

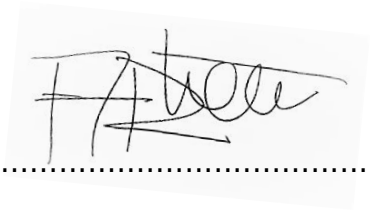
A thesis submitted in partial fulfilment of the requirement for the degree of Master of Science in Public Health

by

Fiorella Farje De la Torre
Peru

Declaration:
Where other people's work has been used (from either a printed source, internet or any other source), this has been carefully acknowledged and referenced in accordance with departmental requirements.

The thesis `Human resources for health with intercultural competency for the provision of health services to indigenous population in Peru´ is my own work.

Signature:  .....

56th Master of Public Health/International Course in Health Development (MPH/ICHD)
16 September 2019 – 4 September 2020
KIT (Royal Tropical Institute)/Vrije Universiteit Amsterdam
Amsterdam, The Netherlands

September 2020

Organised by:

KIT (Royal Tropical Institute)
Amsterdam, The Netherlands

In co-operation with:

Vrije Universiteit Amsterdam (VU)
Amsterdam, The Netherlands

Table of Content

Table of Tables

Table of Figures

Abbreviations

AIDESEP	Interethnic Association for the Development of the Peruvian Forest
AISPED	Comprehensive Health Care in Excluded and Dispersed Populations
CENSI	National Centre for Intercultural Health
CEPAL	Economic Commission for Latin America and the Caribbean
CNA	Native Communities Modality
DGRH	Directorate General for Human Resources Development Management
DIRESA	Regional Health Directorates
EBI	Bilingual Education Modality
HIV	Human Immunodeficiency Viruses
IDRH	Human Resources Development Institute
INDEPA	National Institute for the Development of Andean, Amazonian and Afro-Peruvian Peoples
INEI	National Institute of Statistics and Informatics
INMETRA	National Institute of Traditional Medicine
INS	National Institute of Health
ISTP	High Technical Education Institution
MAIS-BFC	Comprehensive Health Care Model with a family and community approach
NGO	Non-Governmental Organization
PAHO	Pan American Health Organization
PFETSIA	Training Programme for Nurse Technicians in Amazonian Intercultural Health
PROFAM	National Family and Community Health Training Program
SERVINDI	Intercultural Communication Services
SIS	Integral Health System
TB	Tuberculosis
UGEL	Local Educational Management Units
UHC	Universal Health Coverage
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Populations Fund
UNIA	National Amazonian Intercultural University
URACAAN	Autonomous Regions of the Nicaraguan Caribbean Coast
US	United States
USAID	United States Agency for International Development
WHO	World Health Organization

Glossary

Traditional medicine "is the set of diverse health practices, approaches, knowledge and beliefs that incorporate plant, animal and/or mineral based medicines, spiritual therapies, manual techniques and exercises applied individually or in combination to maintain well-being, as well as to prevent, diagnose and treat disease." (National Institute of Health, 2014, p. 14)

Interculturality "refers to the existence and equitable interaction of diverse cultures and the possibility of generating shared cultural expressions through dialogue and mutual respect" (UNESCO, 2013, p. 8)

Intercultural health facility: "A health facility that has been evaluated and has met more than 80% of the standardized criteria, which will see the incorporation of the intercultural approach in the management of the health facility, revaluation of traditional medicine, human resources that serve with cultural relevance, and institutionalizes citizen participation." (Ministry of Health, 2019a)

Indigenous population: The elements of indigenous peoples are: "historical continuity, that means, they are societies prior to conquest or colonization; territorial connection (their ancestors inhabited the country or region); and distinctive political, cultural, economic, and social institutions (they retain some or all of their own institutions)." (International Labor Organization, 2009, p. 9)

Cultural competence "is the set of congruent behaviors, attitudes, and policies that come together in a system, agency, or amongst professionals and enables that system, agency, or those professionals to work effectively in cross-cultural situations" (Cross *et al.*, 1989, p. 28)

Abstract

Title: Human resources for health with intercultural competency for the provision of health services to the indigenous population in Peru.
Background: Evidence on health inequalities between indigenous people and non-indigenous people is abundant. Despite the efforts of governments to address these, cultural barriers continue to be one of the most important causes of indigenous people's limited access to health services.
Objectives: This thesis aims to explore and analyze, at public policy and intervention levels, the different initiatives aiming at the development of human resources for health with intercultural competencies for the provision of health services to indigenous people in Peru.
Methods: A literature review was the research method for this thesis. Inclusion criteria were literature published in English and Spanish between 2010 and 2020.
Results: Human resources in Peru face several challenges in the incorporation of the intercultural health approach. There is no guideline to ensure the systematic incorporation of the intercultural approach in the education and training of health professionals. Evaluations and research are lacking to assess the effectiveness of the intercultural competency skills employed by health workers and whether this leads to positive health outcomes and identifies related challenges.
Discussion
The education and training of health professional on cultural competences have demonstrated a positive impact on their attitude and awareness regarding indigenous people's health problems. The concept of cultural health, however, is as yet unclear for health professional and health authorities. The latter has led to variation in how the concept is applied in the provision of health services as well as in health training programmes and their evaluation. Further research is needed to identify the critical aspects of the education and training of human resources for health in intercultural competencies and their application to the provision of health services. Finally, standardization of indicators for measuring the application of competency is needed to allow comparison of studies.

Key words: human resources for health, indigenous peoples, cultural competency, intercultural approach, Peru

Word count: 12,432

Introduction

I am a Peruvian sociologist who was born and raised in Lima. Before finishing my bachelor, I was already working as a fieldwork researcher in the rural areas of Peru. I was 22 years old when I had my first experience working with indigenous communities and I could experience the disadvantages and inequalities they have to face in their everyday life. Since then I decide to contribute, by doing research, to their development. In 2015 when I started my work in the Faculty of Public Health and Administration in Cayetano Heredia University in Lima, I could work more specifically in the field of health inequalities and learned more about the problems of access, affordability, acceptability and quality concerning health care.

During my studies in the master's in public health at KIT, I could reflect into many topics, but the problems in human resources caught more my attention. The past decades there has been more interest from the Peruvian government, national and international organization to increase the acceptability of the health services through the incorporation of the intercultural approach. The focus for the improvement of the services have been based on the perception of the indigenous population, which is essential to adapt the health services; however, I realise that the challenges, limitation and problems that the human resources face while incorporating the intercultural approach and the development of skill and attitudes are indispensable if the health services want to be improved.

In that sense, and inspired by the Health Labour market framework, this thesis aims to explore on the public policy ground as well as in the implementation of guidelines, programmes and interventions for the development of human resources for health and the intercultural competency. Through this literature review, I want to provide recommendations on further research on the topic as well as next steps to be done by the Ministry of Health to improve the different actions being displayed to reduce the health inequalities that remain in the indigenous population.

1 Background

There are approximately 476.6 million indigenous people in the world, 46.4% of whom live in lower-middle income countries, and 11.5% in Latin America and the Caribbean. Globally, 18.2% of the indigenous population lives in poverty (less than US$1.90 per day), compared to 6.8% of non-indigenous people. Globally, the indigenous population is 20% more likely to have informal work, as 86.3% of the indigenous population works in the informal economy compared to 66.3% of the non-indigenous population. The socio-economic vulnerability faced by this population is shown not only by the informality of the work but also by the difference in the quality of the work, the wages and the discrimination they experience (International Labor Organization, 2019). Because of these conditions, indigenous people are more likely to reduce their quality of like and die younger. The gap in life expectancy between indigenous and non-indigenous is, for instance, 20 years in Australia and Nepal, 17 years in Canada and 13 in Guatemala (United Nations, 2018). Moreover, indigenous peoples had countless barriers to access to health systems. Starting by the differences of language, lack of understanding of their practices and costumes and illiteracy, followed by financial limitations to pay for the services, preventing access even if the health services are available (United Nations, 2015).

In Latin America, the population belonging to the indigenous groups is around 45 million and comprises more than 800 ethnic groups (CEPAL, 2014). Despite representing about 10% of the population and 40% of the rural population of the region, they have been marginalized and are highly vulnerable in terms of health and human rights, social and economic equity. They present a higher incidence of poverty and extreme poverty, illiteracy and unemployment, and poor health indicators compared to the non-indigenous population (CEPAL, 2014). The first step some Latin American governments made was to modify their policies and constitution to recognize their country as a multi-ethnic and multicultural nation (Bello, 2004; Pratt, 2010). Moreover, since the decade of 1990, most countries of the region have elaborate policies, strategies, plans and interventions to incorporate an intercultural approach in the health system "in order to guarantee intercultural management models and health care; culturally relevant health services and medical staff with intercultural competencies" (United Nations, 2015, p. 90).

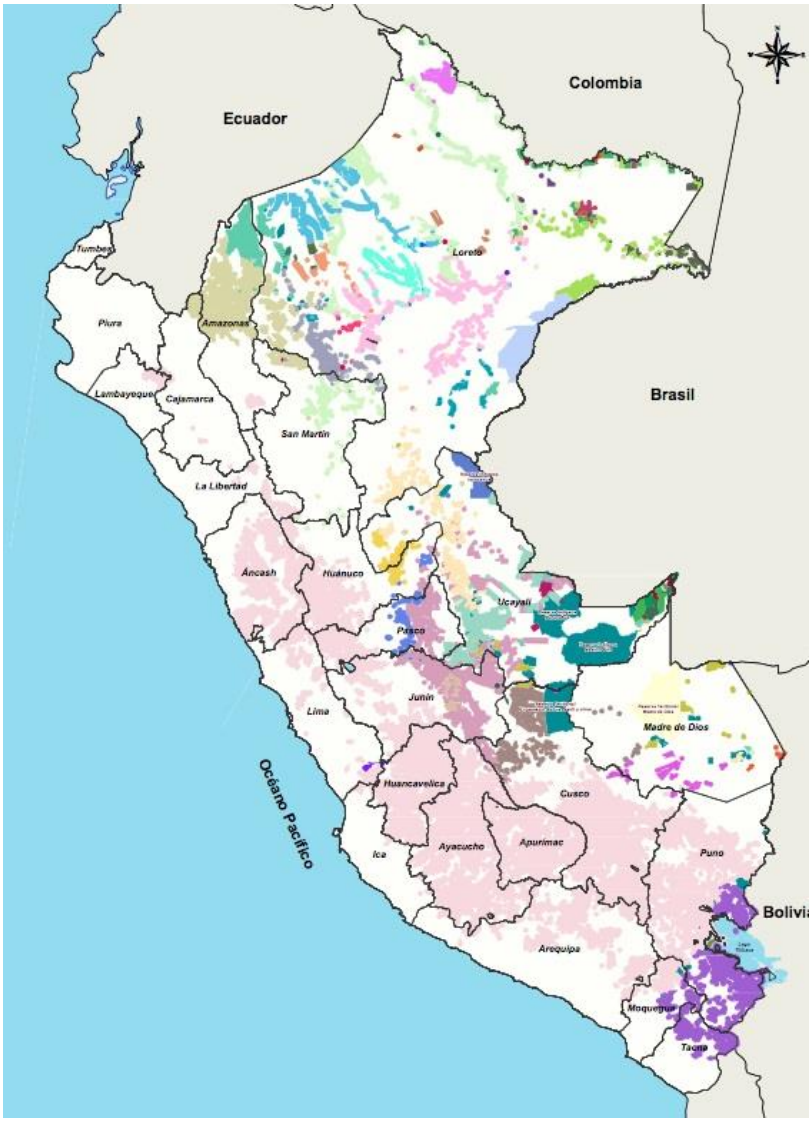
Considering the culture asymmetry between indigenous and non-indigenous, the intercultural approach implies reconceptualize the practices "the others" with a sensitive view, respect and non-discrimination. Thus, the challenge of this approach is to achieve a system with an equitable and respectful dynamic between cultures (Pan American Health Organization, 2009). In the same line, Cross et al. (1989) define cultural competence as "the set of congruent behaviors, attitudes, and policies that come together in a system, agency, or amongst professionals and enables that system, agency, or those professionals to work effectively in cross-cultural situations" (Cross *et al.*, 1989, p. 28).

In Latin America, the term "intercultural" has been linked exclusively to refer to the indigenous peoples (López, 2001). In Peru, there are authors who point out that the "interculturality" is still a concept under construction (SERVINDI, 2005) and that it generates confusion in health personnel because it is a perspective that is not very developed during the basic training as health professionals (Salaverry, 2010). The Ministry of Culture of Peru defines culturally relevant-public services (*servicios públicos con pertinencia cultural*), such as health services, to those that incorporate an intercultural perspective in the management and provision of services, and this implies the "adaptation of all service processes to the geographical, environmental, socioeconomic, linguistic and cultural characteristics (practices, values and beliefs) of the service's area of attention" (Ministry of Culture, 2015, p. 37). The Ministry of Culture also states that these services have to be non-discriminative, bilingual, and respectful of the cultural perspective. In addition, the Ministry of Culture mentions that one of the key areas in which the intercultural approach should be incorporated is in human resources. It points out that human resources are a key factor for the institution in which they provide the service, noting that all staff must be sensitized to issues of cultural diversity and non-

discrimination, must have intercultural skills in order to provide a quality service and must have knowledge of the country's multiculturalism (Ministry of Culture, 2015).

Such an approach is especially relevant in Peru, such indigenous people represent 19.2% of the total population, organized in 55 indigenous or native population, from which 51 are from the Amazon and 4 from the Andes. According to the third census of native communities carried out in Peru in 2017, only 32% of the native communities in Peru have a health facility, of which 92.3% is a health post (INEI, 2018). In the following map shows the geographic distribution of the ethnic group, representing each of them with a different colour.

Figure 1 Map of indigenous peoples in Peru



Source: Database of indigenous or native peoples (Ministry of Culture, 2020)

On another note, is important to consider the politic context. The deconcentration and decentralisation of the health sector since the 2000s in Peru have benefited the poorest and most remote populations (Ugarte and Bardalez, 2006). This political process has provided a legal framework for national, regional and local governments to assume responsibility for government policies in the health sector and for "local governments to have a technical and administrative regulatory role regarding health in their jurisdiction”

(Defensoría del Pueblo, 2008, p. 136). Decentralized health sector agencies include the National Health Institute (INS), the Human Resources Development Institute (IDRH), and the Integrated Health System (SIS). It is these decentralized bodies, together with the Ministry of Health departments, that deal with indigenous health issues, and that are responsible for promoting and developing the main policies related to indigenous peoples (Defensoría del Pueblo, 2008).

2 Problem statement, justification and study objectives

In Peru, despite the efforts to develop health initiatives that reduce health inequalities and to adapt the services to local realities and cultures, the gap between services and indigenous people has remained and they are still the population segment with the least presence and utilization of services (Cevallos and Amores, 2009).

A large number of studies have provided substantial evidence of the influence of culture on worldviews and how these, in turn, influence ways of understanding, perceiving and experiencing health, disease and healing of indigenous populations (Alarcón, Vidal and Neira, 2003; Fernández Juárez, 2004). Because of this extensive body of knowledge on beliefs, local expressions and cultural practices, most intercultural health policies and strategies have focused on the incorporation of traditional medicine and collaboration with traditional health agents in health services, as well as the recovery and re-evaluation of lost ancestral knowledge and sociocultural practices. In Latin America, governments also created offices and other bodies (Del Cid, 2008).

In Peru, most initiatives have taken place at the local level and these have tended to "appropriate" some traditional therapeutic practices in an isolated manner, without recognizing and respecting the indigenous health system. One example is the use of particular medical plants; another the incorporation of vertical birthing position, while criminalizing and prohibiting the practices of traditional birth attendants outside health facilities (for home births, for example) (Portocarrero, 2016). Other shortcomings of the intercultural approach have also been noted in practice. One of them is that the approach has not taken into account the cultural aspects of community life and self-determination and self-government (Boccara, 2007). Another problem lies in the "cultural determinism", which uses merely the culture of the population to explain the health problem and its solutions, leaving aside any possible relationships with political, economic and social factors (Portocarrero, 2016). There has also been a reflection on the difficulties health workers face when having to adapt services to different cultures and contexts, creating a mismatch between the organization and delivery of services, the performance of health workers, and the practices and dynamics of multicultural populations (Cevallos and Amores, 2009). This last problem is the one which this literature research wants to focus on.

Human resources are the fundamental pillar of the health system and for the effective and sustainable development of health policies, but it is only in the last decade that interest has grown, and more attention has been placed on addressing related challenges (Núñez et al., 2015). In 2006, the "Call for Action of Toronto 2006-2015: Towards a Decade of Human Resources in Health for the Americas" meeting was held. This was organized by the Pan American Health Organization (PAHO) to mobilize national and international actors to join efforts to promote, strengthen and develop human resources in the Americas region. The meeting emphasized that human resources are the foundation of the health system and that they are essential to ensure the capacity of the health system to provide equitable access and quality for all (Pan American Health Organization, 2005). Almost ten years later, in 2017, the 56th Executive Board of the World Health Organization (WHO) Regional Committee for the Americas approved the "Human resources strategy for universal access to health and universal health coverage" for the Region of the Americas (Pan American Health Organization, 2018). In the analysis of the situation carried out for this strategy, reference is made to inequities in the availability and distribution of health personnel, as well as the high mobility of the indigenous population in rural areas. But the

analysis also showed how in these underserved areas, such as those in which indigenous population live, human resources do not have the profile, competencies and adequate training to work according to the intercultural approach that these areas require (Pan American Health Organization, 2018). Likewise, WHO stated in 2016 that, if countries want to assure universal health coverage, they must work towards making the education, labour market, and the employment strategies for human resources in health consistent with the needs and expectations of the most vulnerable populations (World Health Organization, 2016).

Although the cultural health practices of indigenous populations, as well as intercultural health services in Peru, have been widely researched, the needs, challenges and problems faced by human resources in incorporating the intercultural approach into public health services and health care for the indigenous population have not been sufficiently explored. This study sought to fill this knowledge gap.

2.1 Study objectives

The main objective of this literature review was to explore and critically analyze the Peruvian institutional and normative framework, as well as interventions, related to the development of intercultural competencies in human resources for the provision of health care to indigenous populations, in order to make recommendations that allow to improve and adapt the design and implementation of these policies, strategies and interventions for improved health equity.

This main objective was subdivided into the following specific objectives:

1. Identify the normative and institutional framework for the development of human resources with intercultural competences to provide health care for the indigenous populations in Peru;
2. Identify common problems and challenges in the implementation of intercultural health policies, strategies and programmes in Peru, as well as relevant other settings with presence of indigenous people;
3. To find evidence on how other countries have managed the education and training on intercultural competence for the health care of the indigenous population;
4. To make recommendations to the Ministry of Health as to how to improve the competencies and skills of human resources in intercultural health.

3 Methods

A literature review was chosen as the research method for this study. This method is usually used to give an overview of a certain topic and identify, for instance, a gap in research and create an agenda (Snyder, 2019).

Literature was identified using two search engines (Google and Google Scholar) and the Vrije Universiteit Amsterdam online library that include 140 searching databases. Also, websites of the World Health Organization and Pan American Health Organization, Peruvian Ministry of Health and Ministry of Culture and other relevant national and international organizations were searched for additional grey literature. Yet, given that "electronic searches lead to only about ten percent of the articles that will comprise an exhaustive review" (Randolph, 2009, p. 7), the references of the chosen articles were also reviewed (snowballing), identifying those relevant for this study, then the references of those articles, and so on until the saturation point was reached. Inclusion criteria were a) literature from the last 10 years, between 2010 to 2020, and b) literature published in English and Spanish.

A pilot was carried out to adjust the terms to be used for the search, some of the key terms were "human resources for health", "indigenous peoples", "cultural competency" and "intercultural health". The final search terms and their combinations are detailed

below. First, a general search took place, mixing the terms in the problem/issue and variables columns, to be added later the last column.

Table 1 Search terms

Language	Problem/issue		Variables		Geographic focus
English	Human resources for health	AND	Indigenous people Cultural competence intercultural communication Public policies Education Training	AND	Peru Latin America
Spanish	Recursos humanos en salud		(Pueblos) indígenas Salud intercultural competencia intercultural Políticas Públicas Educación Capacitación		Perú América Latina

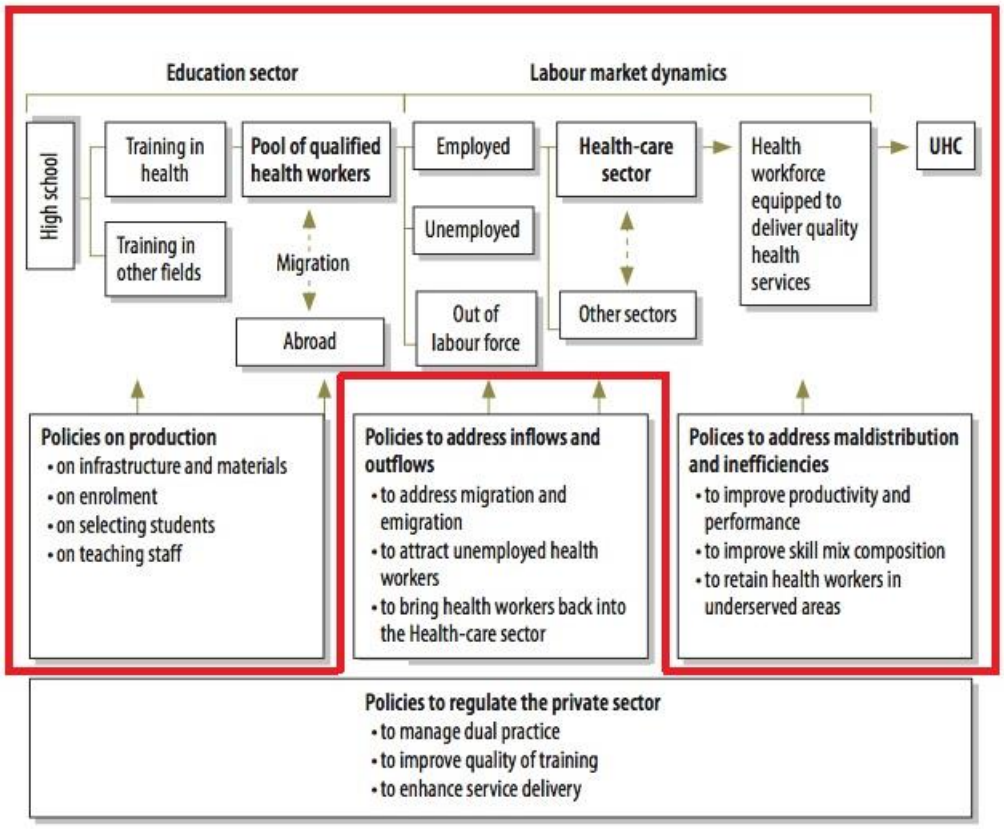
After identifying the main programmes implemented in Peru, a specific search was made using the names of the programmes.

Spanish	MAIS-BFC PROFAM Programa de Formación de Enfermeros Técnicos en Salud Intercultural Amazónica	AND	Evaluación Análisis Informe	AND	Ministerio de Salud Perú

Finally, the framework used was the Health Labour market framework and policy level for attaining Universal Health Coverage (UHC) (Sousa *et al.*, 2013). This framework provides a comprehensive approach to explore the workforce in health through four categories of public policies and its impact on the education sector and labour market dynamics (see Figure 2).

For the purpose of this research, only part of the framework will be used. The objective of this research doesn't aim to explore policies that regulate the private sector, neither those that address the migrations and emigration problems in the sector. As it was stated, the main focus is to identify the policies and the actions implemented in relation to the development of the intercultural health and the challenges in the education and training in human resources in cultural competencies. In that sense, the focus will be on two of the policies blocks suggested by Sousa et al. (2013): policies on production and policies to address inefficiencies.

Figure 2 Health labour market framework and policy level for the attaining universal health coverage



Source: Sousa *et al.*, 2013

4 Study results/findings

This chapter is organized into three sections. The first section is the results for the international literature search on human resources and inter-cultural competency education and training. The second part explored on the Peruvian policies on the production of health professionals, and finally, the third section presents the policies and strategies developed by the Peruvian government concerning the performance of human resources in intercultural health.

4.1 International literature on human resources for health and (inter)cultural competence training

International literature was searched to explored in other countries' experiences and find innovative approaches on how to improve attention for intercultural competencies in the health system as a strategy to reduce health equity gaps for indigenous peoples.

Regarding the effectiveness of the integration of the cultural component and the health outcome, studies present different results. A systematic research conducted between 2002 and 2013 of the cultural competency in health care for indigenous people found, based on 28 publication from Australia (7), New Zealand (3), United States (2), Canada (1) and a cross-national study from New Zealand and Australia, that there was a potential, but no conclusive, evidence of the effectiveness of the cultural component practices that benefit the health care for indigenous people. Besides, in the health's education sector, students that incorporate the cultural perspective in their studies have a more open attitude, awareness and are more prepared to face the challenges of working with the indigenous population as well as generate a more equal relationship with them (Bainbridge *et al.*, 2015).

Another study conducted in Canada states that the educations and training programmes do not guarantee the implementation of a change of behaviour of the health worker of the cultural competency. Likewise, the management staff of a facility could also not support the effort and time-consuming processes that imply the incorporation of the cultural approach in the facility, while also they don't have the support of the local authorities as some implementation processes are not mandated (Baba, 2013). Besides, when qualitative methods studies are review, results show a confusion on the concept of cultural competence and how to put it in practice. In addition, the authors emphasize in the importance of methodological rigorousness in the study designs, since the review was a problem that persists (Downing, Kowal and Paradies, 2011). As the cultural competency skills are recognized as essential, current research advocates for the development of more research to address different ways how this competency could be embedded (Oelke, Thurston and Arthur, 2013).

Clifford et al. identified sixteen interventions focused on improving cultural competency for indigenous health care, eleven were for American indigenous and five for Australian indigenous contexts. The interventions were in the area of education and training, culturally specific programmes and health care provided by indigenous health workforce. In terms of education and training, the review reported that two of seven studies found statistically significant on the improvement in the knowledge outcomes of the health worker - such as understanding of cultural concepts and identifying specific problems of the indigenous population- and four of five that evaluate the confident of the health worker related to cultural competency, reported statistically significant improvement. Besides, in terms of intervention designed, the review found a difference between `culturally tailored´ programmes which are programmes that are designed for the general population and are adapted for increasing the acceptability of the indigenous population; and a second type of programme that are the `culturally sensitive´ programmes which are interventions designed specifically for the indigenous people. Both types of programmes reported an impact on the patient's satisfaction. Finally, the inclusion of indigenous health workforce - which are health worker with indigenous origin- increased adherence of indigenous

patients to specific services (cancer screening and diabetes treatment). However, it is important to mention that the review notes low, weak and low-quality studies that support the findings as well as the lack of evidence of the effectiveness of the intervention to improve the cultural competency in the health facilities (Clifford *et al.*, 2015).

In relation to the integration of indigenous health workforce into the health system as a strategy to increase engagement with indigenous patients, another study on Australian's aboriginal notes that this requires careful planning, monitoring and supervision, because of the high rates of trauma indigenous health professionals could present due to racism and interpersonal violence. This could affect their performance in the provision of services (Herring *et al.*, 2013).

Extensive literature was found in the United States (US). Countries like the United States over the last decade showed a significant increase of the incorporation of the concept of `cultural competency´ in the training of health professionals the last decade (Fleckman *et al.*, 2015), as a consequence of increased migration of people from different cultural backgrounds in the country (Betancourt and Green, 2010). Moreover, in the US, the approach to the cultural competence has changed, going from a more 'categorical approach' were the training was more focus on the values, beliefs and practices related to a particular culture, to a perspective where the focus is on development of a set of skills in the health workers in order to improve the care, for instance, "(1) methods, such as using the explanatory model—that is, asking questions to elicit a patient's understanding of his or her illness, (2) strategies for identifying and bridging different styles of communication, (3) skills for assessing decision-making preferences and the role of family, (4) techniques for ascertaining the patient's perception of biomedicine and his or her use of complementary and alternative medicine" among others (Betancourt and Green, 2010, p. 583)

Another systematic review of 19 reviews on the impact on interventions to improve cultural competency of health professional and the improvement of the health care to ethnic minorities shows that most of the reviews got evidence of the relation between the cultural competency and the provider outcome and the access and utilization of the health care, but no for the improvement of the users' health outcome (Truong, Paradies and Priest, 2014). Likewise, other systematic review have found limited or no significant findings on the impact of cultural competency training on patient's health outcome (Lie *et al.*, 2010; Renzaho *et al.*, 2013)

In Latin America, the health gaps in terms of access and exclusion of indigenous population due to cultural barriers are widely recognized. A study in Chili identified that one of the key barriers of access to health services is the lack of intercultural competency among human resources. The intercultural approach can be reached by working together with the indigenous communities and an equal relationship with the indigenous health system, in addition to the development of technical and human skills in the health professionals (Hasen, 2012). Meanwhile, a study in Mexico also shows the importance of training human resources on intercultural competencies for the increase of access to health services of older migrant indigenous people (Juárez-Ramírez *et al.*, 2014). A qualitative study in Sierra de Totonacapan, an indigenous region in Veracruz, Mexico, found evidence that racism was an institutionalized practice. The racism was manifest by race-based discrimination like dark skin colour and stigmatization of the indigenous people, due to cultural aspects like language, practices, habits and costumes - among other kinds of discrimination, such as linked to socio-economic status. These practices were institutionalized, for instance, through the imposition of Western medicine over the traditional and the power relations between health professionals and traditional birth attendants (Dörr and Diertz, 2020). Furthermore, a review of the public policies related to indigenous health, traditional medicine and interculturality in Mexico between 1990-2016 showed that the efforts regarding training on intercultural health were related to the role of traditional medicine, complementary curative practices like acupuncture, intercultural dialogue and indigenous language. Even so, health workers' intercultural skills were still

found to be a weak aspect of the provision of services to the indigenous population (Campos, Peña and Paulo, 2017).

Regarding the education of health professionals, the creation of intercultural universities in Latin America since 2005 were initiatives that aimed at the revaluation and strengthening of the knowledge of the indigenous people, the promotion of the local languages, and the preservation of their culture (Ávila, 2011). While the focus of the universities has not been on the training of health professionals, some of them offer a health-related career. This is the case of the University of the Autonomous Regions of the Nicaraguan Caribbean Coast (URACCAN), created in 1992 by a group of indigenous leaders. For both undergraduate and postgraduate levels, they offer the career of Management of Intercultural Health and Management in Care and Prevention of HIV (Mato, 2011). The review made by Mato of five intercultural universities and one higher education centre concluded that the creation of these institutions has enabled the indigenous population to access higher education and improve the education curriculum in line with indigenous communities' perspectives. Even so, challenges still exist regarding the 'stiffness' of the education policies and guidelines to accredit these institutions and the lack of funding, but also racial discrimination by authorities and the population, economic limitations faced by students as well as a lack of scholarships (Mato, 2011).

In Chile, one study found that there was only one university –the School of Nursing of the Pontificia Universidad Católica de Chile- that incorporated the intercultural health approach in the curriculum, through one course during the first year of studies. The interviews for this study were done among academic and administrative university authorities, who showed that the concept of intercultural health was not a clear concept and was interpreted in different ways: some didn't mention the two different health systems or reduce the differences worldview to 'communication barriers'; others assumed that most of the careers already incorporated the intercultural concepts; while again others seemed to have little interest in revaluing traditional medicine (Painemilla, Sanhueza and Vanegas, 2013).

4.2 Peruvian policies on production (education) of human resources with intercultural competency

Access to education has been a problem for the indigenous population in Peru. Not only in economic terms but also because of the difference in the level of education that does not allow indigenous to compete with non-indigenous youth (Espinosa, 2017). Despite having economic support from organizations such as AIDESEP for the financing of scholarships, the high rate of desertion generated the culmination of economic support (Espinosa, 2017). It is only since 2014 that the Peruvian government has approved a norm in which it classifies the population from Amazonian indigenous communities as extremely poor in order to facilitate their participation in programmes such as `Beca-18`[1] (Peruvian Government, 2014a). Within the scholarship programme, there are two modalities for the indigenous population, the Native Communities modality (CNA) and the Intercultural Bilingual Education modality (EBI). However, the admission of students depends on the regulations of each university, both public and private. This also includes the types of courses of study available. In 2014 only four universities accepted students under the CNA scholarship modality and in 2017 the number of universities increased to twenty. None of these universities offered medical careers, such as law or dentistry, for this type of scholarship. Universities such as Cayetano Heredia admitted CNA students for the career of Health Administration but not for medicine (Espinosa, 2017)

There is literature from Latin American countries that evidence the creation of intercultural universities, this is the case of Mexico, Bolivia, Colombia, Ecuador, Nicaragua, Panama and Venezuela. In Peru, there are four intercultural universities of which only one is in operation, the National Amazonian Intercultural University (UNIA) located in the city of

[1] Beca-18 (in English scholarship-18) is a scholarship programme for young people who have just completed their basic studies.

Pucallpa, Ucayali region. Anyhow, this university does not offer careers for the education or train of health professionals (Espinosa, 2017).

One intercultural-specific training programme identified in Peru is the Training Programme for Nurse Technicians in Amazonian Intercultural Health (PFETSIA) implemented by the indigenous organization Interethnic Association for the Development of the Peruvian Forest (AIDESEP). Although this is an action implemented by an indigenous organization and not from the Ministry of Health, it has worked to train human resources to be integrated into the public health system and is therefore relevant for the purposes of this research.

4.2.1 AIDESEP and the Training Programme for Nurse Technicians in Amazonian Intercultural Health (PFETSIA)

The main objective of the programme implemented from 2005 to 2013, was to train young indigenous people as health professionals who can work in areas poorly covered by the government, usually rural areas where mestizo personnel do not want to go[2]. The programme had a focus on developing skills in intercultural health care that would increase the access of indigenous people to the public health services, and to develop the knowledge and ancestral technologies of this population (Cárdenas and Pesantes, 2017). The programme began by making arrangements with a High Technical Education Institution (ISTP) and the local educational management units of the Ministry of Education (UGEL) to carry out a "pedagogical innovation" in the technical nursing curriculum. This consisted of the incorporation of the intercultural approach in a transversal way in the curriculum. The first pilot was carried out in Atalaya between 2005-2008, and later replication of the programme took place in Bagua (2009-2012) and Nauta (2010-2013).

Cárdenas and Pesantes (2017) conducted a study to identify the achievements and difficulties in the implementation of the programme and the incorporation of the intercultural approach of the programme's graduates. One of the particularities identified in this human resource training programme is the adaptability of the programme – that is, the capacity to adapt the content and principles promoted by the programme to the reality and characteristics of the indigenous peoples participating in it. Thus, in each of the agreements with the ISTPs, adjustments were made to the curriculum, which has a duration of three years (Cárdenas and Pesantes, 2017). The design of the programme's curriculum was built on indigenous knowledge with the help of local scholars; the curriculum, therefore, incorporated knowledge of both medical systems, portraying Western biomedical knowledge as one more among others, with contributions, but also limitations (Cárdenas, Pesantes and Rodríguez, 2017). Knowledge and practices of indigenous traditional medicine were not seen as an instrument for biomedical practice only, but one side in a dialogue between two equally valued and recognized health systems In that sense, AIDESEP sought with this programme the formation of human resources that could play the role of "hinge" between the two medical systems, allowing the meeting of knowledge to increase the quality of care (Cárdenas, Pesantes and Rodríguez, 2017).

A study conducted in two health posts in the Amazon Region where graduates of the PFETSIA were working shows that there was an increase in the appreciation of the service by the users, who mentioned that the intercultural practices of health personnel increase their confidence in the services they offer. Some of these practices imply a respectful and horizontal relationship with the users, a relationship with the communal authorities and indigenous wise men, as well as the revalorization of the medicinal plants (Chávez et al., 2015). At the same time, the study points out the limited institutional support from the health sector to make these practices sustainable and with greater impact. Similarly, the

[2] The "mestizo" is a racial ethnic category that refers to the hybridization, as Marisol de la Cadena would call it, between the Spanish and the indigenous cultures of Peru (De la Cadena, 2006). The term originated during the first years of colonization and has continued until the present day. It is currently a category used in national censuses.

working conditions of health personnel in primary care positions limit their capabilities and impact their motivation - for instance, not having a boat from the health post to transfer patients and being exposure to hazardous conditions during transport (Chávez et al., 2015).

In addition, the programme presents other types of difficulties and challenges. One of these is the lack of recognition and accreditation/certification of the Programme by the Ministry of Education. The study notes that the greatest difficulty is that the Ministry of Education cannot recognize nor accredit the programme because that would places indigenous knowledge equal to the academic knowledge (Cárdenas and Pesantes, 2017). Also, is difficult for the graduates of the PFETSIA to implement the intercultural approach, while the rest of the medical personnel working in the facility have not been trained and do not share or recognize the intercultural approach. In this regard, since the Nurse Technicians have less decision-making power in the management and administration pyramid of the health services, they do not receive support for the development and implementation of intercultural activities (Chávez et al., 2015). Finally, although the organization seeks with the programme to train professionals and integrate them into the Ministry of Health's public health system, graduates experience difficulty in entering and remaining in the Ministry of Health's labour market. The instability of the health sector, as well as the precariousness of employment, encourages a high turnover, which is detrimental to the relationship that health providers can develop with the population (Chávez et al., 2015).

4.3 Peruvian policies to address performance of human resources with intercultural competency

This section will start with a brief background on health policies for indigenous population in Peru followed by the policies, strategies and programmes on the performance of the human resources for health and the intercultural approach.

4.3.1 Brief background on the health policies for indigenous peoples and intercultural health in Peru (1970-2010)

During the 1970s and 1980s, health care for the indigenous population in Peru was provided by missions and Non-Governmental Organizations (NGO) that set up communal health kits and conducted emergency campaigns in native communities (Eyzaguirre Beltroy, Fallaque Solís and Lou Alarcón, 2007). In the 1990s, the National Institute of Traditional Medicine (INMETRA) was created, which twelve years later would be replaced by the National Centre for Intercultural Health (CENSI) (Peruvian Government, 2003), a lower-level organism under the National Institute of Health (INS). Today, the CENSI is the governing body for intercultural health and indigenous peoples in Peru and is responsible for proposing policies, strategies and standards that address the health problems of indigenous peoples, as well as promoting research in the field of indigenous health (National Institute of Health, 2020b). While the successes and contributions made by the CENSI are acknowledged, their limitations are also recognized. Some of its successes are the design of the General Plan of the National Strategy for the Health of Indigenous Peoples (2010-2012) (CENSI, 2009); the organization of a population census in part of Cusco Region – together with the National Institute of Statistics and Informatics (INEI) in 2007 – which succeeded in incorporating the variable of "indigenous self-identification" instead of "mother tongue" as an ethnic classification criterion, and a proposal for the incorporation of the ethnic variable into the health information system, among others (Defensoría del Pueblo, 2008).

However, the CENSI still lacks a regulatory framework and sufficient leadership capacity to implement the policies at all levels of government. These issues were identified by the Ombudsman Office as barriers for the incorporation of the intercultural approach in all levels of care (Defensoría del Pueblo, 2008).

In 2004, the National Health Strategy for Indigenous Peoples and in 2005 the Technical Standard for Vertical Childbirth Care with Intercultural Adaptation were approved. Moreover, in July 2006, the government approved the "Technical Health Standard for the Incorporation of Human Rights, Gender Equity and Intercultural Based Approaches" (Ministry of Health, 2006b). This standard is relevant because establishes criteria for the design, implementation and evaluation of policies, plans, programmes and projects at the national and local level to incorporate the intercultural approach, as well as the human rights and gender-based approach in the health sector. In terms of human resources and the intercultural approach, mentions that the way to develop competencies is receiving training of the local cultures and the gender dynamic of the indigenous communities as well as trained them to develop skills for intercultural dialogue. For the latter, the technical document doesn't provide specifics indicators for the interaction between health workers and users. For this point, the Ministry of health recognizes the importance of the role of the education sector in this regard (Ministry of Health, 2006a).

Finally, in 2008, the Observatory on Interculturality and Indigenous Peoples' Health Rights was established (Ministry of Health, 2008), with the aim of providing information and a monitoring platform to help strengthen policies and generate informed action to reduce the social and health gaps among indigenous peoples. While the Observatory seeks to achieve its objectives through the organization of different initiatives with the regional and local authorities, it also seeks to do so through the dissemination of information about the perceptions and knowledge of indigenous peoples. Some information the Observatory considered important to disseminate is the reasons why indigenous people feel excluded from the health services, which the most common are difference of language, the imposition of care, or lack of knowledge of traditional medicine in health facilities (National Institute of Health, 2020a). A report published one year after the Observatory was created mentions that between 2009 and 2010 there was an increase in the information shared by the regions on intercultural initiatives, nevertheless, these reports were unevenly distributed by the regions (Rivas, 2010). Moreover, while this is a highly relevant initiative for the knowledge management of intercultural health in the country, there is no mention or focus on human resources in health. Likewise, the study mentions that as there is a wide heterogeneity of ethnic and cultural groups in Peru, is necessary to design innovative forms of care that avoid the imposition of a model of care (Rivas, 2010). What Rivas does not explore is in the possible process for innovation in care, or the role of human resources in the adaptation of services, neither the needs for the development of competencies.

By the year 2010, the progress in intercultural health and the incorporation of the intercultural approach for the care of indigenous people has been in two dimensions: the creation of technical standards and the cultural adaptation of health services. In terms of standards, there is the Health Strategy for Indigenous Peoples, the Standards for the Incorporation of the Gender, Human Rights and Intercultural based approach, as well as Health Guides prepared by the Ministry of Health (Correa Aste, 2011). This is in addition to the Sectoral Policy on Intercultural Health approved in 2016 (Peruvian Government, 2016). However, it has been noted that the implementation of these standards has not been possible, due to a lack of funding, especially for the training of technical staff. Regarding the cultural adaptation of health services, efforts have been concentrated mainly in the area of maternal health, leaving other health domains unaddressed. Generally, it has been pointed out that one of the greatest difficulties facing the health system is the availability of professionals who are trained to offer appropriate care for the indigenous population, and subsequently their retention in those areas (Correa Aste, 2011).

4.3.2 The normative and institutional framework for the development of human resources in intercultural health care for indigenous populations in Peru

There is a recent (2010-2020) normative framework for the health of indigenous peoples and the role of human resources in intercultural health in Peru. Over the last 10 years, there have been three regulations related to indigenous populations that have a relation with the development of human resources in intercultural health. The first one was developed in 2014 when the Ministry of Health approved the technical document 'Intercultural Dialogue in Health' as elaborated by the CENSI (Peruvian Government, 2014b). The objective of this document was to establish technical guidelines for the use of intercultural dialogue. However, it is noteworthy that the skills the document is oriented to develop are mainly for personnel working in Regional Health Offices, Regional Health Managements Offices, and the Local Health Offices. These are only administrative instances, leaving aside the personnel who are working in the primary level facilities. These personnel are mentioned among the social actors and they are called, conversely, "facilitators" of intercultural dialogue. This regulation presents an inconsistency when defining the implementation: while it is mentioned that only the personnel of the regional and local offices are to be trained, the personnel working at the first level of attention are –as facilitators– the ones deemed "responsible for compliance with the provisions of the technical document" (National Institute of Health, 2014, p. 40).

Although this document establishes the framework for the work of intercultural dialogue at different levels of government, there are guidelines that emphasize the importance of the intercultural dialogue and the different steps to follow for its implementation. An example is a guide for maternal and newborn care make an emphasis in five moments of the intercultural dialogue: the recognition and acceptance of the user as a person with different practices but equal rights; knowledge of what they think and feel and the opportunity to exchange knowledge in a bidirectional way; collaboration to create a more equal relationship and built a bond between the health worker and the user; a systematic cooperation between personnel and population with a common goal; and finally, an association which means to share resources as well as the responsibility, with respect and in a horizontal way (Ministry of Health, 2010).

In 2016, a Sectoral Policy on Intercultural Health was approved by a Supreme Decree. In the analysis and research carried out to support the policy, it is noted that in Peru and other countries in the region, the incorporation of the intercultural approach has increased the use of services by indigenous populations, but that utilization remains limited due to a lack of physical access, as well as a lack of recognition of needs, perceptions and practices by the health system (i.e., acceptability). In that sense, one of the four proposed work actions to achieve the revaluation of the traditional knowledge – which is the general aim of the policy – concerns the strengthening of the capacities and abilities of human resources in intercultural health (Peruvian Government, 2016). Until now a plan for the implementation of the policy is missing.

In 2018, the National Plan for Professional Training and Skills Development of Human Resources in Health 2018-2021 was approved. This plan aims to ensure that human resources in health have adequate professional skills (concepts and practical skills) and human competencies (attitudes) that respond to the expectations, demands, and needs of the population. This objective is proposed to be achieved by promoting the training of human resources and by verifying that the developed capacities are actually put into practice, thus promoting quality, equity, and interculturality (Ministry of Health, 2019b). However, this plan is recent and to date, there has been no research to evaluate the implementation of the plan or its results.

These three regulations have been designed by identifying important health gaps that affect the indigenous population, and compared to the past decade, the focus in human resources it becomes more relevant. However, in practice, these policies and regulations

lack funding for effective implementation at a national level as well as an adaptation of them to the particular health problems of the indigenous people in each region. Therefore, different offices of the Ministry of Health, some of them with the technical support of international organizations, had developed manuals and methodological guidelines to guide and direct health personnel in the implementation of the intercultural approach. One of these is the guide for the implementation of the model of tuberculosis (TB) care with an intercultural approach in Asháninka communities at the first level of care, an ethnic group that live in five regions of the country -Ayacucho, Ucayali, Pasco, Junín, Cuzco and Loreto. This was designed by the Tuberculosis Prevention and Control National Strategy and Pathfinder International to oriented the regional and locals offices on how to train their personnel in the incorporations of intercultural care for patients with TB (Ministry of Health *et al.*, 2015). The guide first gives an overview of the particular characteristics of this ethnic group followed by identifying the barriers of access for this population to the TB programme. In addition to the economic and social barriers (illiteracy), the cultural barriers are fundamental for the adequation of the services: lack of knowledge of the cultural context, the absence of recognition of the language barriers, the opening hours of the facility without agreed with the population and the way how the procedures are not explained to the patients by the health workers. The guide also works on the barriers of communication with the indigenous population, empathic listening and assertive communication (Ministry of Health *et al.*, 2015).

Similarly, there is a module on "Maternal and newborn care with gender equity and interculturality in the framework of human rights in health" (Ministry of Health, 2010) which was made as a guide for the implementation of the Technical Standard for the Care of Vertical Childbirth with Intercultural Adaptation (Ministry of Health, 2005). Some of the cultural barriers identified for the Andean Region are the way how the personnel relate with the traditional birth attendance by no allowing them to give belly massages; besides not eating soups after the birth, the lack of patient of the personnel during the care; doctors that do not talk the local language, among others (Ministry of Health, 2010).

The necessity for adequate the health facilities to this approach prompted the Ministry of Health with other institutions and organizations as the Ministry of Culture, CARE-Peru, the United Nations Populations Fund (UNFPA), and the Interethnic Association for the Development of the Peruvian Forest (AIDESEP), to design a guide on how to implement the intercultural approach in the first level of care. For that purpose, they stablished 21 standards and 26 criterions organize according to the four lines of action of the Sectorial Policy for Intercultural Health (2016): management of the facility and the quality of care, the value traditional health system has for the personnel, how human resources provided care with cultural pertinence and, finally, the participation of the community in the organization and evaluation of the health care services. An intercultural health facility is, then, the one which meets at least 80% of all the criterions (Ministry of Health, 2019a). This document establishes with more clarity the responsibilities of the implementation by assigning the responsibility of systematization and evaluation to the national level, the management of the human resources and financing to the regional level and the implementation of the standards to the local level (Ministry of Health, 2019a).

The work promoted by the government in the last ten years has represented progress on the construction of an institutional framework for the intercultural health in the country compared with the past decade. It also represented the basis for the development of the human resources in health with an intercultural approach as some normative have been approved in this regard. There is still an emphasis on the communication skills and how an intercultural dialogue show be implemented despite other cultural have been systematically identified. In the same line, is not until 2019 that the Ministry of Health has established a more grounded criterion. For the implementation of the approach. Moreover, the literature shows the need to adapt the interculturality to specific problems, such as TB or maternal mortality, as well as to the particularities of each region, since, for instance, is not the same to work with Asháninkas in the Amazon or Quechuas in the Andes.

The Peruvian Ministry of Health recognizes that one of the critical factors in meeting the goals set for the health sector is human resources. As a result of the commitments made in the "Toronto Call to Action 2006-2015," the Directorate General of Human Resources Development Management (DGRH) was created. The DGRH has promoted a series of actions in the health and education sectors, but the literature search indicated that were two the ones that explicitly incorporate the intercultural competency in the development of the human resources as one of their objectives. These are the Model of Integrated Health Care with a Family and Community Focus (MAIS-BFC) and its subprogramme, the National Family and Community Health Training Programme (PROFAM).

4.3.3 The MAIS-BFC and PROFAM programme

A research carried out in the Huancavelica Region (Andean region) identified two Health Networks that are implementing the MAIS-BFC Model -also called just MAIS Model; these Networks also had the support of Medicus Mundi. The study focused on the Tayacaja Health Network because the implementation of the intercultural approach was a recent experience. Two facilities were chosen within this network. The qualitative study, which took into account the period 2015-2017, indicates that the Tayacaja Health Network began implementing the model on the initiative of the officials and was done with its own financial resources, trying to change the structure and organization of the services to incorporate the intercultural approach. The research shows that was in the area of maternal health, and specifically the mother`s choice of the type of birth, where the intercultural approach had more presence. Likewise, the implementation of the intercultural approach in the establishment took place in three areas. The first one is regarding the relation of health worker-patient, mainly the attitude of respect for their customs and the generation of trust in the services, as well as a change the way information was transmitted. A second change happened at the infrastructural level, as warmer spaces were more comfortable and increase acceptability. Finally, changes happened in the relationship with traditional health agents, despite persistent disagreements with them (Liu Pinedo, 2019). However, despite having identified areas of change, the study demonstrates that the implementation of the intercultural approach lacks conceptual clarity among the health personnel which the health professional who receives the training worked with, as well as lack of clarity of the staff in charge of the facility (Liu Pinedo, 2019). After 5 years of implementing the Model, managing to cover 61 of the 87 health facilities that belong to the Tayacaja Health Network, there is no other evaluation or systematization of the implementation of the Model.

In 2017, an adaptation of the MAIS model was made specifically for the Loreto Region called "Model of Integrated and Intercultural Health Care for the Pastaza, Corrientes, Tigre, Marañon and Chambira River Basins in the Loreto Region 2017-2021" (Peruvian Government, 2017). This model was created because it was identified that the health situation of indigenous peoples in this region was critical and that there was a lack of quality and culturally relevant health services. Among the deemed causes of this problem were the management and organization of services that were not articulated with the community or other government agencies, and the little knowledge that is available about indigenous medicine in the area. With regard to the management and organization of services, was proposed to personalize follow-up of the community's health, incorporating in the establishment services of the indigenous health system – for example, the attention of midwives and healers, vertical birth options, and manuals with terms that the community uses. In terms of human resources development, the Model proposes to develop capacities and competencies in health personnel with a "Training Plan for Intercultural Health". However, it is mentioned that such a plan would imply a review and validation of manuals, guidelines, care protocols, among others, in local language and using common terms for the indigenous community. In terms of knowledge management, it proposes to implement an Amazon Intercultural Health Information and Research Center, which would aim to systematize the ancestral practices and knowledge of

indigenous communities to inform decisions and improve processes (Ministry of Health, 2017). Unfortunately, there is still no research on the Model or the proposed actions.

On the other hand, the PROFAM was designed in 2009 by institutions such as the DGRH, representatives of unions such as the College of Nurses and the College of Obstetricians, representatives of the Regional Health Directorates (DIRESAS), universities such as the Universidad Nacional Mayor de San Marcos and the Universidad Peruana Cayetano Heredia, among others, and received technical assistance from international organizations: United States Agency for International Development (USAID), PAHO and the Italian Cooperation Agency (Ministry of Health, 2011). This programme sought to have a holistic vision of the training of health personnel, developing theoretical-conceptual knowledge and reinforcing their skills and abilities, but also developing attitudes in the human resources in health that "make knowledge and skills expressed through the human interrelationship of health professionals with their peers, individuals, family and community, assuming ethical conduct and solid principles such as the affirmation of human values, the search for truth and the practice of interculturality as a basis for interrelationship" (Ministry of Health, 2011, p. 21). The planning and design of the programme were based on social demands and is based on that that the programme seeks to consolidate the health team working in a facility (Ministry of Health, 2011).

PROFAM has three phases of training: the first is a Diploma in Integrated Care with a Focus on Family and Community Health, aimed at doctors, nurses, obstetricians and nursing technicians; the second phase is the Specialty in Family and Community Health, aimed at doctors, nurses and obstetricians; and finally, a third phase is the Specialty in Family and Community Medicine, aimed only at doctors (Ministry of Health, 2011). The first phase is the most relevant for the purposes of this research because work with the human resources of the primary health level; therefore, the focus of the following literature will be on that.

A study conducted in 2015 explored the effect of the "Diploma in Integrated Care with a Focus on Family and Community Health" on access, coverage, organization and management of the facility in a health post in the province of Churcampa, department of Huancavelica. The research used a quantitative method based on records and documents provided by the health facility. The results indicate that, of all the aspects improved in the establishment as a result of what was learned in the Diploma, only one is related to the incorporation of the intercultural approach. This change was the marking of services "with an intercultural approach". The study does not give details of how the intercultural character is understood in the signposting of the facility. Likewise, in terms of indicators, the study reported that the intercultural adaptation changed from a `basic level´ to `advanced level´ in the period of two and a half years (July 2012 to December 2014), without defining the indicator of the level. However, the study also showed that one of the obstacles to providing care with a focus on the family, the community and interculturality was the lack of knowledge of the rest of the health personnel about the MAIS approach. This is compounded by a weak relationship with social actors, authorities and leaders. It mentions the need to improve the organization and management of health facilities in order to improve service quality (Domínguez and De la Cruz, 2015).

A research conducted in 2018 on the experience of the implementation of MAIS Model and PROFAM between 2013-2015 indicates that the first stage of the Diploma obtained good results; however, it did not have sustainability due to the high rotation of personnel. The second phase of PROFAM, which had a national scope, showed that only some regions were able to sustain the programme and develop a continuous training plan. The factor that determined that the programme persisted overtime was the support of other organizations, such as in Huancavelica region where there was support from the International Cooperation of Medicus Mundi Navarra, PAHO in the Amazon region and Solaris in Andahuaylas, Apurimac region (Polo Ubillús, 2018).

5 Discussion

Over past decades, there have been plenty of efforts to reduce the health gaps suffered by indigenous populations and to improve development of health services that respond to their needs. The incorporation of cultural competences and an intercultural approach in the delivery of health services has been the strategy most countries, high-income countries but also countries in the Latin America Region, have used in this regard.

In terms of the education/production of human resources for health, the study results indicate that available literature and research on the incorporation of cultural competence in the education of the health workforce is skewed towards high-income countries like the United States, Australia and New Zealand. In Latin America, results were focused more on the limitations and challenges of the few educational institutions that undertook to integrate the intercultural approach in their curricula. This is in part explained by the fact that related policies and programmes are of more recent nature in this region than in the mentioned high-income countries.

Available studies addressing the incorporation of cultural competencies in the education of the health workforce do not offer strong evidence for a positive impact. On the one hand, some studies indicate that the incorporation of cultural competencies has had a positive impact on the confidence of health professionals to provide health services to the indigenous population (this is also the case of the PFETSIA programme). Evidence suggests that this has led to a more open attitude, increased awareness and better preparation to face the challenges of working with this population, as well as better skills to establish a more horizontal relationship with the service users. On the other hand, a systematic review found that only two out of seven studies showed statistical significance regarding the increase of knowledge. In addition, qualitative studies have demonstrated that confusion exists on the concept of `cultural health´ and how this is translated into action. These results suggest that the impact of the incorporation of cultural competencies by health workers' education has been more relevant for health workers' attitude than for the conceptual and theoretical area. Available evidence shows a lack of high-quality studies and reviews, able to generate strong evidence.

In Peru, the results indicate that there is a gap in access to health education for the indigenous population. The lack of economic resources in addition to the different on the education level lead to inequalities between the indigenous and non-indigenous population. In that sense, even if the economic factor is covered, the difference in the performance generates a high rate of desertion. Moreover, the limited literature found does not present reasons why careers like medicine are not part of scholarship programmes established to benefit indigenous people. Indeed, more research in this field is required. Besides that, and amidst a limited offer of intercultural training in health in the country, the Training Programme for Nurse Technicians in Amazonian Intercultural Health (PFETSIA) is an interest experience in the education of the indigenous workforce.

In line with the international literature, the PFETSIA programme had a positive impact on the perception of the users about the services. Besides, whenever health workers showed limitations regarding the incorporation of the intercultural approach this was related to the lack of support from the health teams. Despite this experience representing a successful case study, more generally there is not enough research to evaluate the impact of the programme on the education and training of the human resources for health, nor on the health outcomes of the population that received health care from these indigenous health workers.

In terms of the policies and normative guidelines in the health sector, the results suggest that the efforts made by the Peruvian government have focused on the revaluation of traditional medicine and the related improvement of health services for the provision of intercultural maternal health care. The literature confirms that the Peruvian health policies have not been focused on the production of human resources with intercultural

competencies, nor on the development of materials or infrastructure that enable the development of health careers with cultural sensitivity. Even if government guidance focused on the development of human resources for health, it relied on the education sector to provide the specifics indicators and to incorporate cultural competencies in health workers' training study program. This is the case, for instance, of the Technical Standard for Vertical Childbirth Care with Intercultural Adaptation.

Regarding the Health labour market framework (Sousa *et al.*, 2013), the results indicate that the inter-cultural competency has different ways to be incorporated in the design of health training programmes and their evaluation. No standardizes indicators have been defined that allow to compared outcomes and have more conclusive results. However, these are important findings, even if not conclusive, on the topic.

Qualitative research has shown the different experiences of the health workers as regards the embedding of the intercultural competency in the provider care for clients. The international literature, as well as studies conducted in Peru, coincide when they show the confusion among health workers regarding the concept when incorporating the intercultural competency in the delivering of the services. However, there were not sufficient evidence and studies have nor presented stronger results. In that sense, more thoroughly designed qualitative research is needed in this area of research.

Another result is regarding the integration of the indigenous workforce. In the international context, it has been shown that this could increase the adherence of indigenous populations to specific services (e.g. cancer screening and diabetes treatment). Contrary to this, another study notes the risk of having indigenous health workers in the delivery of services to the indigenous population due to the high rates of discrimination they experience. The Peruvian experience regarding the Training Programme for Nurse Technicians in Amazonian Intercultural Health, implemented by AIDESEP, have acknowledged some challenges as well. Some aspects that make the work difficult is, for instance, the small number of personnel who receive training in the intercultural approach. In this regard, several studies pointed out the difficulty faced by some health technicians in proposing and implementing some of the learning in intercultural health due to the resistance of the health personnel with whom they work because they are not familiar with the approach. The medical hierarchy also limits their role as intercultural agents. This makes it difficult to incorporate mechanisms to offer a quality service appropriate for indigenous people's needs and customs.

The efforts to develop adequate health services for the indigenous population and the development of human resources with intercultural competence are fairly recent in Peru if we consider that the policies that addressed the health problems of this population were created in the 1990s and implemented with greater force only from 2000. The regulatory framework is undoubtedly an important aspect in the field but before 2010 it had a focus on the creation of different units within the government, especially at the national level, to manage the problem of indigenous health issues. Besides, the focus was on the creation of national plans and strategies, as well as the dissemination of knowledge and information available about the different cultures and their health practices and perceptions.

In the followed ten years, there was increasing attention for developing a normative framework that improved the services for the indigenous population and the fundamental role of culture in the design of the health services; and to focus on the importance of human resources for health for the improvement of health systems in multicultural settings. However, and using the classification of Clifford *et al.* (2015), the results highlight that, although the creation of policies and national standards are necessary in terms of a general normative framework, this must be tailored to the regional characteristics as well as the particularities of the ethnic groups. Moreover, the technical support from international agencies has played an important role in the design of guidelines for more `culturally sensitive' interventions. It was not until 2019 that the Ministry of Health designed a Manual for the adaptation of the intercultural approach in the first level

facilities. This could be understood as the need of the Ministry to clarify the processes of implementation of the approach, as well as to have more precision of the roles that each level of government has to take for effective implementation.

The data suggest that the different policy level actions related to intercultural health in Peru have tended to focus on three aspects. The first one is the inclusion of the indigenous people´s needs in national health plans and strategies. This has also been a form of recognition of the health gap between the indigenous and non-indigenous populations. An example of this focus is the work done by CENSI, for instance, with the design of the General Plan of the National Strategy for the Health of Indigenous Peoples. A second focus has been on the generation of information on the indigenous population, in order to know *who*, *how many*, and *where* they are. The most important work in this area has been the two censuses of indigenous communities carried out, the first in 2007 and the second in 2017. In addition, the Observatory on Interculturality and Indigenous Peoples' Health Rights was created as an information platform to help generate policies, strategies and programmes based on accurate information and evidence. Finally, the third focus has been on the adequacy of services based on the perceptions and needs of the indigenous population.

Likewise, the results also indicate that in terms of the intercultural competency training the MAIS-BFC Model and it subprogramme, the PROFAM, have few and low-quality research. Two studies report the implementation of the Model and a Diploma in the Huancavelica Region. The outcomes reported were general and didn't specify the operationalization of indicators. Both studies mention that one of the barriers in the effective implementation of the Model was the lack of knowledge of the rest of the health team of the approach. Moreover, the high rotation of the personnel affects the implementation of the approach. Besides, regions like Huancavelica, that have the technical support of external organizations (Medicus Mundi, PAHO and Solaris), have greater sustainability over time. This suggests that the regional offices do not have sufficient resources, technical, logistical or human, to be able to implement the programme adequately.

On another note, the evaluations of interventions are more focused on the knowledge outcomes -with no significant results- and the outcome in the access and utilization of the services more than the health outcome of the users.

Finally, the results indicate that only a few studies were found that analyze the political context on the implementation of the policies. For instance, the decentralization process of the health sector in Peru has contributed to a fragmented health system; while the steering roles and budgets of the intercultural health belong to different sectors and levels of government. The promotion of policies and programmes in intercultural health belong to the CENSI; however, actions are carried out by different bodies of the Ministry of Health, such as the Directorate-General for Human Resources Development Management (DGRH), and by different sectors, such as the Ministry of Culture and the Ministry of Education. Although some regulations can contribute to having an institutional framework for the development of human resources with an intercultural approach, the implementation depends on the initiative of regional and local level and is highly linked to the "good will" of the authorities and health personnel. Thus, the level of implementation and enforcement of the different policies and regulations is different in each region.

The framework chosen for this research also allowed to analyze the relation of the educational sector and the training programmes in (inter)cultural competencies and the impact on the performance of the health workers on the provision to health care for indigenous people. Moreover, the challenges faced in the implementation. The analysis confirms the importance of the cultural competency in the training in health as well as a change of attitude from the health worker in the provision of the services. While these results should be taken into account when considering to further explore the challenges on the incorporation of the intercultural competency in the health care system and the

design of policies, the generalizability of the results is limited by the quality of the research reviews. Most of the systematic reviews reported low-quality of research methods, moreover, the peer-reviews and the government documents presented a lack of operationalization of the intercultural competency.

6 Conclusions and recommendations

6.1 Conclusions

Health inequalities remain among indigenous people compared to the non-indigenous people worldwide are of increasing concern because the slow results achieved despite all the efforts. The challenges related to human resources for health have therefore become more relevant in the last two decades and have motivated interventions and international commitments. However, the field of study to explore the performance of health workers in terms of their inter-cultural competencies for the improved care of indigenous people as well as the incorporation of the intercultural approach in the health care system is still limited and lacks high-quality studies. Therefore, the objectives of this research were, through a review of the literature and based on the Health Labour market framework, to explore and analyze the evidence on the Peruvian institutional and normative framework as well as interventions, related to the development of the intercultural competency in human resources.

The analysis indicates that in Peru there has been a progressive change in the design of policies and the normative framework related to the indigenous population in the country, as well as an improvement of the health services with an intercultural approach. In the decade between 2000 and 2010, the focus was on the creation of different units within the government to regulate and promote the policies and strategies needed. The creation of CENSI is one of the most important examples of the institutions created for this purpose. This institution also was in charge of undertaking research and dissemination of research available and knowledge management. In the following years, the policies were more focused on the improvement of the health services and the incorporation of the intercultural approach.

Two programmes implemented by the public sector and one by an indigenous organization were identified: the MAIS-BFC Model and its subprogramme PROFAM, and the AIDESEP's technical nurse training programme, respectively. For the three of them, very few studies exist that analyze and evaluate their implementation and results. Nonetheless, some achievements but also limitations and challenges were identified. For instance, the programmes impacted on the relationship health worker-users, mainly in terms of the more respectful attitude for indigenous customs and the generation of trust in the services, as well as on communication and the way information was transmitted. Regarding difficulties found, health professionals still needed to better deal with language barriers. Moreover, there was a lack of conceptual clarity regarding 'interculturality'. Different definitions of interculturality were used due to the lack of adequate operationalization. For health personnel, the concept of interculturality was diffuse and abstract and led to different interpretations of what a health service with an intercultural approach should be.

The political context has not been considered in the analyzes of the policies of the education sector nor the implementation of the training programmes in Peru. For example, the process of decentralization of the state and the deconcentration of the health sector has generated a disarticulation of the different initiatives related to intercultural health. Currently, there is the CENSI and also the Directorate-General for Human Resources Development Management (DGRH), while also the Ministry of Health, the Ministry of Culture and the Ministry of Education are involved in the design and development of intercultural initiatives. Furthermore, as the use of the normative framework is not enforced, the implementation in the Regions differs.

Regarding the health-related education sector, the international literature review presents different outcomes of the benefits of the incorporation of the cultural competence in the education and training of human resources. While some studies demonstrate a weak impact on knowledge outcomes, others present evidence for impact on the awareness and confidence of the health worker in the provision of services. In Peru, there is not an education framework that generates the conditions to systematically integrate the intercultural competence in the education of human resources for health. Besides, there is no evidence that intercultural education is enforced in the universities in the country. The implementation depends on what each university decides to adopt and put into practice. Also, no medical careers are offered through scholarship programmes dedicated to indigenous students. While some other health-related careers are offered (i.e. Health Administration by the Cayetano Heredia University in Lima), due to the low performance and insufficient economic support - even though the scholarship also covers costs of living- most of the students do not finish their studies. The education of indigenous people as health workers is an underexplored area of research. Furthermore, the training of indigenous health workers to provide health services to the indigenous population, such as done by PFETSIA, is only represented in the literature by few studies and is an area for further research.

6.1 Recommendations

One of the first steps to go deals with **research**. Further research is needed to identify the critical aspects of the education and training in inter-cultural competencies in health professionals, together with the implementation of the intercultural approach in the health facilities and its impact on improving the quality of services according to the indigenous people needs. Also, research to generate stronger evidence on the effectiveness of health workforce training in cultural competency and on health outcomes of the indigenous people is essential. Qualitative research is essential to gain more insights into the (mis)understanding of the interculturality concept among health professionals and its translation to concrete action. Research reports need to go hand in hand with the dissemination of research to strengthen programmes in intercultural health for human resources for health, and to strengthen other programmes and related policies. In line with that, conduct inventories of relevant experiences in Peru, the region and worldwide, would give important insights.

Since Peru is recognized by the constitution as a diverse and multicultural country, the design of culturally sensitive **programmes** is indispensable. Based on the research recommended before, the design of different interventions should be based on the population's health needs and, most important, health worker needs for the provision of quality and culturally pertinent services in each region. While past interventions have had a focus on maternal and newborn health, it is necessary to think broader and start looking to a more comprehensive approach of the indigenous' health, for instance, consider other health problems such as cancer, diabetes or mental health. The interventions should take place, first of all in regions with a higher presence of indigenous population and secondly regions where most affected ethnic groups are.

The evaluation and analysis of the programmes are indispensable to learn about the challenges and limitations. In Peru, there is a lack of evaluation of programmes and interventions that need to be done to reformulate the strategy on how to improve the implementation of the approach in the health facilities in the country. Besides, the interventions in each region are different which lead to the generation of inequalities not only among the indigenous and non-indigenous population but within the different ethnic groups in the country. A first step will be a depth analysis of how each region has incorporated the intercultural approach and consequently design a plan based on the needs. Besides, identify the technical and economical requirements each region have and the possible collaboration with national and international organizations.

In parallel, a **policy** should be developed by the Ministry of Education to regulate the integration of the intercultural perspective in the education of human resources in health and define the governmental units that will be in charge of the enforcement and supervision of this policy. The regulation of the educational institutions -for instance, in the selection and enrolment of students- must guarantee equal opportunities in the selection and enrolment of indigenous and non-indigenous people in medicine and other medical-related careers. In that sense, regulation most consider the mentoring need by indigenous students, as well as economic support that these students require. Besides, it is important to strengthen the coordination between the health sector, the education sector and the Ministry of Culture. The work of the three sectors is essential.

Finally, the standardization of **indicators** for an inter-cultural competence health system will allow comparison of studies. This could be, as Cross et al. (1989) proposed, aimed at differentiating the set of behaviours, attitudes and policies, to which I would add a set of clear concepts and knowledge needed to understand the intercultural approach. Without a well-defined concept of inter-cultural health, the new behaviour and attitudes would not be effective.

7 References

Alarcón, A., Vidal, A. and Neira, J. (2003) 'Conceptual bases of intercultural health', *Rev Méd Chile*, pp. 1061–1065. Available at: https://scielo.conicyt.cl/pdf/rmc/v131n9/art14.pdf.

Ávila, A. (2011) 'Universidades interculturales y colonialidad del saber', *Revista de Educación y Desarrollo*, 16. Available at: http://www.cucs.udg.mx/revistas/edu_desarrollo/anteriores/16/016_Avila.pdf.

Baba, L. (2013) *Cultural safety in First Nations, Inuit and Métis Public Health. Environmental scan of cultural competency and safety in education, training and health services*. Prince George, BC: National Collaborating Centre for Aboriginal Health.

Bainbridge, R. *et al.* (2015) *Cultural competency in the delivery of health services for Indigenous people*. Australia: Canberra: Australian Institute of Health and Welfare & Melbourne: Australian Institute of Family Studies. Available at: https://researchonline.jcu.edu.au/39726/1/Cultural_Competency_delivery.pdf.

Bello, Á. (2004) *Etnicidad y ciudadanía en América Latina. La acción colectiva de los pueblos indígenas*. CEPAL. Santiago de Chile. Available at: https://www.cepal.org/mujer/noticias/noticias/9/26089/libroetnicidadciudadania.pdf.

Betancourt, J. and Green, A. (2010) 'Linking Cultural Competence Training to Improved Health Outcomes: Perspectives From the Field', *Academic Medicine*, 85, pp. 583–585. doi: 10.1097/ACM.0b013e3181d2b2f3.

Boccara, G. (2007) 'Etnogubernamentalidad. La formación del campo de la salud intercultural en Chile', *Revista de Antropoligía Chilena*, Vol.39 Nº2, pp. 185–207. Available at: https://scielo.conicyt.cl/pdf/chungara/v39n2/art03.pdf.

Campos, R., Peña, E. and Paulo, A. (2017) 'A critical examination of public policies related to indigenous health, traditional medicine, and interculturality in Mexico (1990-2016)', *Salud Colectiva*, 13(3), pp. 443–455.

Cárdenas, C. and Pesantes, M. A. (2017) *Entrecruzando ríos: Sistematización de la propuesta pedagógica de formación de enfermeros técnicos en salud intercultural de AIDESEP*. Instituto. LIma, Perú. Available at: http://repositorio.iep.org.pe/bitstream/IEP/770/2/Cardenas-Pesantes_Entrecruzando-rios.pdf.

Cárdenas, C., Pesantes, M. and Rodríguez, A. (2017) 'Interculturalidad en Salud: Reflexiones a partir de una Experiencia Indígena en la Amazonia Peruana', *Anthropologica*, 35(39), pp. 151–170. doi: 10.18800/anthropologica.201702.007.

CENSI (2009) *Plan General de la Estrategía Sanitaria Nacional. Salud de los Pueblos Indígenas 2010-2012*. Available at: http://www2.congreso.gob.pe/sicr/cendocbib/con4_uibd.nsf/863CDF27AC98E61805257BE800771D9A/$FILE/Plan_General.pdf.

CEPAL (2014) *Los pueblos índigenas en America Latina. Avances en el último decenio y retos pendientes para la garantía de sus derechos*, *Naciones unidas*. Available at: http://repositorio.cepal.org/bitstream/handle/11362/37050/S1420783_es.pdf?sequence=4&isAllowed=y.

Cevallos, R. and Amores, A. (2009) *Prestación de servicios de salud en zonas con pueblos indígenas*. PAHO/OMS. Quito, Ecuador. doi: 10.20452/pamw.3427.

Chávez et al., C. (2015) *El aporte de los egresados del Programa de Formación de Enfermos Técnicos en Salud Intercultural Amazónica de AIDESEP a la salud intercultural. Estudio de caso en dos comunidades de Amazonas*. Lima: IEP. Available at: https://repositorio.iep.org.pe/bitstream/IEP/973/2/documentodetrabajo222.pdf.

Del Cid, V. M. (2008) 'Antecedentes, situación actual y perspectivas de la salud intercultural en América Latina', in.

Clifford, A. *et al.* (2015) 'Interventions to improve cultural competencyin health care for Indigenous peoples of Australia,New Zealand, Canada and the USA: a systematicreview', *International Journal for Quality in Health Care*, 27, pp. 89–98. doi: 10.1093/intqhc/mzv010.

Correa Aste, N. (2011) *Interculturalidad y politicas públicas: una agenda al 2016*. Lima: Pontificia Universidad Católica del Perú and Consorcio de Investigación Económica y Social. Available at: http://www.cies.org.pe/sites/default/files/investigaciones/interculturalidaddocumento.pdf.

Cross, T. *et al.* (1989) *Towards a Culturally Competent System of Care*. Washington D.C.: National Instituteof Mental Health,Child and Adolescent Service System Program (CASSP), Georgetown University Child Development Center. Available at: http://files.eric.ed.gov/fulltext/ED330171.pdf.

Defensoría del Pueblo (2008) *La salud de las comunidades Nativas: Un reto para el Estado. Informe Defensorial Nº 134*. LIma, Perú.

Domínguez, K. and De la Cruz, C. (2015) *Efectos del diplomado de atención integral en la accesibilidad y cobertura -organización y gestión en el Puesto de Salud Cosme, Provincia de Churcampo, Departamento de Huancavelica-2014*. Universidad Nacional de San Cristobal de Huamanga. Available at: http://repositorio.unsch.edu.pe/handle/UNSCH/1510.

Dörr, N. and Diertz, G. (2020) 'Racism against Totonaco women in Veracruz: Intercultural competences for health professionals are necessary', *PLOS ONE*. doi: https://doi.org/10.1371/journal.pone.0227149.

Downing, R., Kowal, E. and Paradies, Y. (2011) 'Indigenous cultural training for health workers in Australia', *International Journal for Quality in Health Care*, 23(3), pp. 247–257.

Espinosa, O. (2017) 'Higher Education for Indigenous Peoples of the Peruvian Amazon Region: Balance and Challenges', *Anthropologica*, 39, pp. 99–122. doi: https://doi.org/10.18800/anthropologica.201702.005.

Eyzaguirre Beltroy, C., Fallaque Solís, C. and Lou Alarcón, S. (2007) *Políticas para eliminar las barreras geográficas en salud*. CIES-CARE. Lima.

Fernández Juárez, G. (2004) *Salud e interculturalidad en América Latina. Perspectivas Antropológicas*. Ediciones. Quito, Ecuador.

Fleckman, J. *et al.* (2015) 'Intercultural competency in public health: a call for action to incorporate training into public health education', *Front. Public Health*, 3:210. doi: https://doi.org/10.3389/fpubh.2015.00210.

Hasen, F. (2012) 'Interculturality in Health: Competence in Health Practices with Indigenous Population', *Ciencia y enfermeria*, XVIII(3), pp. 17–24. Available at: https://scielo.conicyt.cl/pdf/cienf/v18n3/art_03.pdf.

Herring, S. *et al.* (2013) 'The Intersection of Trauma, Racism, and Cultural Competence in Effective Work with Aboriginal People: Waiting for Trust', *Australian Social Work*, 66(1), pp. 104–117. doi: 10.1080/0312407X.2012.697566.

INEI (2018) *III Censo De Comunidades Nativas 2017: Resultados definitivos*. Lima.

International Labor Organization (2009) 'Los derechos de los pueblos indígenas y tribales en la práctica. Una guía sobre el Convenio Núm. 169 de la OIT', (Pro 169), p. 201.

International Labor Organization (2019) *Aplicación del Convenio sobre pueblos indígenas y tribales núm. 169 de la OIT: Hacia un futuro inclusivo, sostenible y justo*. Geneva, Switzerland. Available at: https://www.ilo.org/wcmsp5/groups/public/---dgreports/---dcomm/---publ/documents/publication/wcms_735627.pdf.

Juárez-Ramírez, C. *et al.* (2014) 'La desigualdad en salud de grupos vulnerables de México: adultos mayores, indígenas y migrantes', *Rev Panam Salud Publica*, 35(4), pp. 284–290. Available at: https://www.scielosp.org/pdf/rpsp/2014.v35n4/284-290/es.

De la Cadena, M. (2006) '¿son los mestizos híbridos? las políticas conceptualesde las identidades andinas', *Universitas humanística*, 61, pp. 55–84.

Lie, D. *et al.* (2010) 'Does Cultural Competency Training of Health Professionals Improve Patient Outcomes? A Systematic Review and Proposed Algorithm for Future Research', *Springer*, pp. 317–325. doi: 10.1007/s11606-

010-1529-0.

Liu Pinedo, B. L. (2019) *Estudio de caso: Diagnóstico de desempeño del enfoque intercultural del modelo de atención integral de salud basado en familia y comunidad (MAIS-BFC) en la atención prenatal de los centros de salud de Quichuas y Santiago de Pichus, Tayacaja, Huancavelica,*. Pontifia Universidad Católica del Perú.

López, L. E. (2001) *La cuestión de la interculturalidad y la educación latinoamericana*. Available at: https://red.pucp.edu.pe/ridei/files/2011/08/731.pdf.

Mato, D. (2011) 'Universidades indígenas de América Latina: Logros, Problemas y Desafíos', *Revista Andaluza de Antropología*, 1, pp. 63–85. Available at: https://idus.us.es/bitstream/handle/11441/86942/daniel_mato.pdf?sequence=1&isAllowed=y.

Ministry of Culture (2015) *Servicios públicos con pertinencia cultural. Guía para la aplicación del enfoque interculural en la gestión de los servicios públicos.* Lima: Ministerio de Cultura and USAID.

Ministry of Culture (2020) *Interactive Map*. Available at: https://bdpi.cultura.gob.pe/mapa-interactivo (Accessed: 10 August 2020).

Ministry of Health (2005) *Resolución Ministerial N° 598-2005/MINSA. Norma Técnica para la Atención del Parto Vertical con Adecuación Intercultural*. República del Perú. Available at: https://www.gob.pe/institucion/minsa/normas-legales/252332-598-2005-minsa.

Ministry of Health (2006a) *Norma técnica de Salud para la Transversalización de los enfoques de derechos humanos, equidad de género e interculturalidad en Salud*. Perú. Available at: https://centroderecursos.cultura.pe/sites/default/files/rb/pdf/RM638-2006Normatecnicadesaludparalatransversalizaciondelenfoquedeinterculturalidad.pdf.

Ministry of Health (2006b) *Technical Health Standard for the Incorporation of Human Rights, Gender Equity and Intercultural Based Approaches*. LIma, Perú. Available at: http://bvs.minsa.gob.pe/local/PROMOCION/893_PROM19.pdf.

Ministry of Health (2008) *Observatory on Interculturality and Indigenous Peoples' Health Rights*. LIma, Perú. Available at: http://bvs.minsa.gob.pe/local/MINSA/1587.pdf.

Ministry of Health (2010) 'Atención materna y neonatal con equidad de género e interculturalidad en el marco de derechos humanos en salud: módulo 7', in *Modelo de Intervención para mejorar la disponibilidad, calidad y uso de los establecimientos que cumplen funciones obstétricas y neonatales*. Lima, p. 78.

Ministry of Health (2011) *Programa Nacional de Formación en Salud Familiar y Comunitaria*. Lima. Available at: http://www.minsa.gob.pe/dggdrh/libros/pdf/s3/III-1. PROFAM.pdf.

Ministry of Health *et al.* (2015) *Fortaleciendo las competencias del personal de salud que implementa un modelo de atención intercultural para comunidades Asháninkas en el primer nivel de atención. Guía para el facilitador-Personal de salud*.

Ministry of Health (2017) *Modelo de Atención de Salud Integral e Intercultural de las Cuencas de los Ríos Pantaza, Corrientes, Tigre, Marañon y Chambira en la Rención Loreto 2017-2021*. Lima.

Ministry of Health (2019a) *Adecuación de los servicios de salud con pertinencia cultural en el primer nivel de atención*. Lima.

Ministry of Health (2019b) *Plan Nacional de Formación Profesional y Desarollo de Capacidades de los Recursos Humanos en Salud 2018-2012*. Lima. Available at: http://bvs.minsa.gob.pe/local/MINSA/4940.pdf.

National Institute of Health (2014) *Diálogo intercultural en Salud*. Lima. doi: 10.1017/CBO9781107415324.004.

National Institute of Health (2020a) *Observatorio de Interculturalidad y Derechos en Salud de los Pueblos Indígenas*. Available at: https://web.ins.gob.pe/es/salud-intercultural/observatorio-intercultural/objetivos.

National Institute of Health (2020b) *Salud Intercultural. Acerca del CENSI*. Available at: https://web.ins.gob.pe/es/salud-intercultural/acerca-de-censi/presentacion (Accessed: 24 July 2020).

Núñez et al., M. (2015) 'Andean region policies in planning and management of human resources in health', *An Fac Med.*, 76, pp. 27–33. doi: 0.15381/anales.v76i1.10967.

Oelke, N., Thurston, W. and Arthur, N. (2013) 'Intersections between interprofessional practice, cultural competency and primary healthcare', *Journal of Interprofessional Care*, 27(5), pp. 367–372. doi: 0.3109/13561820.2013.785502.

Painemilla, A., Sanhueza, G. and Vanegas, J. (2013) 'A qualitative approach for incorporation of intercultural health in the curriculum of Chilean universities in regions with large indigenous populations', *Rev Chil Salud Pública*, 17(3), pp. 237–244.

Pan American Health Organization (2005) *Llamado a la acción de Toronto 2006-2015 Hacia una década de Recursos Humanos en Salud para la Américas*. Toronto.

Pan American Health Organization (2009) *La salud de los pueblos indígenas de las Américas: conceptos, estrategias, prácticas y desafíos*. Available at: https://www.paho.org/hq/dmdocuments/2009/53-SPI-conceptos-estrategias.PDF.pdf.

Pan American Health Organization (2018) *Plan de acción sobre recursos humanos para el acceso universal a la salud y la cobertura universal de salud 2018-2023*. Washington, D.C. Available at: https://www.paho.org/hq/index.php?option=com_docman&view=download&category_slug=56-directing-council-spanish-9965&alias=45773-cd56-10-s-pda-rh-773&Itemid=270&lang=en.

Peruvian Government (2003) *Decreto Supremo N° 001-2003-SA*. Available at: https://www.gob.pe/institucion/minsa/normas-legales/254422-001-2003-sa.

Peruvian Government (2014a) *Nº 227-2014-MIDIS*. República del Perú. Available at: https://www.gob.pe/institucion/midis/normas-legales/7324-227-2014-midis.

Peruvian Government (2014b) *Resolución Ministerial Nº 611-2014/MINSA. Diálogo Intercultural en Salud*. República del Perú.

Peruvian Government (2016) *Decreto Supremo Nº 016-2016-SA. Política Sectorial de Salud Intercultural*. LIma, Perú, República del Perú.

Peruvian Government (2017) *Resolución Ministerial N° 594-2017-MINSA*. Available at: https://www.gob.pe/institucion/minsa/normas-legales/189041-594-2017-minsa.

Polo Ubillús, O. (2018) 'Experience with the implementation of the Model of Family and Community-based Integrated Health Care within the National Family Health Strategy', *Rev Peru Ginecol Obstet.*, 64(3), pp. 375–381. doi: https://doi.org/10.31403/rpgo.v64i2100.

Portocarrero, J. (2016) 'Retos de la salud intercultural en el Perú'. Available at: http://insteractua.ins.gob.pe/2016/07/retos-de-la-salud-intercultural-en-el.html.

Pratt, M. (2010) 'La indigeneidad hoy', in De la Cadena, M. and Starn, O. (eds) *Indigeneidades contemporáneas: cultura, política y globalización*. Lima.

Randolph, J. (2009) 'A guide to writing the dissertation literature review', *Practical Assessment, Research, and Evaluation*, 14.

Renzaho, A. *et al.* (2013) 'The effectiveness of cultural competence programs in ethnic minority patient-centered health care- a systematic review of the literature', *International Journal for Quality in Health Care*, 25, pp. 261–269. doi: https://doi.org/10.1093/intqhc/mzt006.

Rivas, A. (2010) *Análisis del impacto del observatorio de interculturalidad y derechos en salud de los pueblos indígenas*. Lima.

Salaverry, O. (2010) 'Interculturalidad en salud', *Rev Peru Med Exp Salud Publica*, 27(1), pp. 80–93.

SERVINDI (2005) *Interculturalidad: Desafío y proceso en construcción*. LIma, Perú. Available at: https://indigenasdelperu.files.wordpress.com/2015/09/interculturalidad-proceso-construccion.pdf.

Snyder, H. (2019) 'Literature review as a research methodology: An overview and guidelines', *Journal of Business research*, 104, pp. 333–339. doi: https://doi.org/10.1016/j.jbusres.2019.07.039.

Sousa, A. *et al.* (2013) 'A comprehensive health labour market framework for universal health coverage', *Bull World Health Organ*, pp. 892–894. doi: http://dx.doi.org/10.2471/BLT.13.118927.

Truong, M., Paradies, Y. and Priest, N. (2014) 'Interventions to improve cultural competency in healthcare: a systematic review of reviews', *BMC Health Services Research*, 14. doi: https://doi.org/10.1186/1472-6963-14-99.

Ugarte, O. and Bardalez, C. (2006) *El proceso de descentralización en salud*. Lima: USAID-PRAES.

UNESCO (2013) *Basic texts of the 2005 Convention on the Protection and the Promotion of the Diversity of Cultural Expressions*. Paris. Available at: https://unesdoc.unesco.org/ark:/48223/pf0000225383.

United Nations (2015) *The State of the World's Indigenous People. Indigenous peoples' access to health services.* Available at: https://www.un.org/esa/socdev/unpfii/documents/2016/Docs-updates/SOWIP_Health.pdf.

United Nations (2018) *Indigenous People: health*, *Department of Economic and Social Affairs*. Available at: https://www.un.org/development/desa/indigenouspeoples/mandated-areas1/health.html (Accessed: 7 August 2020).

World Health Organization (2016) *Health workforce requirements for universal health coverage and the Sustainable development goals*. Geneva, Switzerland.