Transcending global health dogma: an Indigenous perspective

Current perspectives on global health are largely determined and advocated for by people or institutions in Europe or in the USA.[1] Those determining the questions are not diverse, which results in hegemonic solutions for the entire world.[2] Sometimes, on the basis of the arbitrary and problematic comparative category of income alone, a single generalised solution is recommended for the almost 6·5 billion people living in low-income and middle-income countries, from Afghanistan to Brazil, from China to Jamaica. We question whether this approach can really lead to health equity. These solutions are exported and chorused by supporting academics and politicians and become a global dogma. As with any dogma, criticism is discouraged and belief in experts is demanded. We suggest four steps to transcend this approach and allow for plurality.

First, acknowledging that health and pathways to health are defined differently in distinct traditions worldwide.[3,4] Each cultural tradition contributes to the cultivation of a health-care dynamic grounded on its own history, viewpoint, and issues, and guided by specific principles and values. These factors cannot be assimilated into the civilising project—which historically and often still—regards many Indigenous people and traditions as backwards and in need of salvation, development, or modernisation. This fact is ignored by many health-care institutions, both global and local, and acknowledging it might result in new reflections on health care and on a more relevant and nuanced approach to health equity.

The next step is ensuring that people with diverse perspectives are welcomed. The Indigenous concept of rituals of encounter, a ceremonial practice that guides hosts and visitors through their engagement, can facilitate collaboration and cooperation. Groot and colleagues[5] describe such a ritual of encounter, the pōwhiri, which is indigenous to Aotearoa New Zealand. This dynamic ritual is performed in various settings and changes with time and circumstances. The ritual shows what is shared by community members and connects hosts and visitors, allowing both to manage uncertainty and explore their relationship and their challenges and to decide whether cooperation is possible. They add that "it is through such rituals of encounter that Māori (indigenous peoples of Aotearoa New Zealand) establish ways of conversing, listening, witnessing and creating spaces for inter-group encounters that form the foundation of an ongoing dialectics of engagement".[5]

Third, creating a space that is open to diverse perspectives. The same structure and rules of engagement in global health will not lead to equity. Global health spaces, both real and virtual, must be thoughtfully redesigned to change the current stance. An example is the building of a traditional Guarani house at the University of São Paulo (São Paulo, Brazil), after extensive consultation with the Guarani community on how best to include them in an environment from where they have been structurally excluded. The Guarani people participated in the entire process, including the construction, and were helped by volunteers. This cooperative act created a space where they were not just individuals to be saved, but active participants. The Guarani people's strengths, wisdom, rights, and challenges became tangible to academics, which changed the relationship, at least partly, between the academic and Guarani communities.[6] Changing the physical structure was integral to changing structural inequality. What structural changes must be made at global health institutions?

Finally, accepting plurality means inviting diverse, discordant voices and understanding that agreement might not always be possible. Differences need to be respected without a need to dominate or suppress voices, people, and perspectives. Many Indigenous knowledge systems are open to non-Indigenous ideas, but this openness is generally not reciprocated. Indigenous concepts of health are often devalued by non-Indigenous health-care professionals and systems.[7-9] Dialogical approaches aim to expand health-care practices through the inclusion of silenced perspectives, which depends on understanding how knowledge from different cultural traditions became differentiated from other traditions, to what extent are they are translatable to each other, and how some concepts and practices approached from the perspective of a specific cultural tradition are not referred to in distinct semiotic systems.[9]

Indigenous people worldwide have recognised the limits of current concepts of non-Indigenous systems on health, particularly in addressing the link between

specific sociocultural realities and health outcomes.[10] The resultant so-called modern health-care intervention models are inadequate when dealing with people and societies who are resisting the ethos of acceleration that characterises many contemporary societies. Global (and local) health-care systems must embrace people who are often ignored, their words, and their thought systems, in theory, method, and intervention. By rejecting the imposition of an unhealthy, dogmatic vision and encouragement of dialogical approaches, there is an opportunity to create an ethical path to equitable health for all that embraces complexity and the potential that interethnic dialogues bring.

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