

#### **SY14-03**

##### **Globalisation and the Health of Indigenous Peoples** **Papaarangi Reid**

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There are over 370 million indigenous peoples worldwide residing in 90 countries and living in hugely diverse realities.

We represent nations of various population sizes; as small as a few dozen people through to membership of hundreds of thousands. We are frequently regarded as “ethnic minorities” and have been, and continue to be, subjected to policies and practices of colonisation, marginalisation and subjugation which undermine our health and wellbeing and our engagement with our environment and culture.

We also demonstrate diversity in our engagement with the forces that are loosely called “globalisation”. Some indigenous nations own major corporations and participate in the global economy in areas such as fishing, forestry, energy resources, and media. Many other indigenous nations seek similar horizons.

However, very many of us exist at the other extreme of economic engagement. Struggling daily for the basics of life and having a pattern of health that demonstrates that struggle. Even indigenous nations who reside within wealthy countries struggle with equitable access to the determinants of health, to the health care and to quality care leading to inequitable health outcomes.

Despite the engagement, willing or unwitting of indigenous peoples in globalisation, a number of indigenous advocates question whether globalisation holds anything but false promises for us and have labelled globalisation as the new colonisation. This talk will focus on indigenous critique of globalisation and give examples from indigenous health and wellbeing literature.

#### **SY14-04**

##### **Digging Out Indigenous Mental Health: An Exploration of the Role of Cultural Factors in the Mental Health of Indigenous Taiwanese**

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Indigenous Taiwanese are comprised presently of 14 ethnic groups with a total population of 483,378 (2007), accounting for 2.1% of the general population.

Evidence from studies of physical and sociocultural anthropology indicates that these indigenous populations are descended from Malayo-Polynesian stock and speak languages stemming from the Austronesian linguistic family. These groups can be distinguished from each other not only by geographic distribution, but also by extensive differences in physiognomy, language, and sociocultural institutions.

An early Formosan study provided evidence suggesting that the rate of severe alcoholism, although already higher in indigenous populations compared to the general Taiwan population, was relatively low at the time, while later surveys suggested that lifetime prevalence rates of alcoholism were much higher in all studied indigenous groups than in the Chinese in Taiwan. A recent study shows high rates of alcoholism in two indigenous groups. The interrelationship between cultural environment and mental health must be held firmly in mind since mental health is enmeshed with economic and political concerns such as poverty, malnutrition, social change, dislocation and acculturation.

A number of investigators have suggested that low degree of acculturation might play an important role in the development and maintenance of alcoholism, while many indigenous Taiwanese believe that the loss of their culture is the primary cause of many of their existing social problems, especially those associated with alcohol while the protective role of cultural factors is yet undetermined. And although it has been proposed that acculturation is associated with mental health, its effect is not consistent cross research. A recent study shows that while higher level of acculturation was related to lower prevalence of alcoholism in one ethnic group, its effect was no longer significant in another group. Still, ethnic identity was significantly associated with alcoholism in these two groups.

On the aftermath of the Morak typhoon, some reports have suggested that indigenous people living in disaster areas did not suffer trauma while others researchers who employed PTSD screening scales to measure the health impact suggested otherwise. This raises a number of questions about the validity of scales used since presently there is no scale taking into account cultural differences and linguistic nuances. Finally it has been observed that in some indigenous communities in disaster areas traditional ceremonies are held in order to comfort residents. The effects of these practices on mental health merit further investigation.

#### **Symposium 15- Primary Healthcare and Public Health**

#### **SY15-01**

##### **Bridging the Divide: Public Health Challenges in Community Oriented Primary Care**

**Sian Meryl Griffiths**

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Primary care is recognized as the bedrock of good healthcare systems – but what are the public health contributions and how should we prepare our workforce to contribute to the delivery of good primary health care to our populations?

Definitional issues bedevil the answer to this question. There is general confusion about the differences between primary care and primary healthcare in the literature-with interchangeability of terminology adding to the lack of

clarity. There is further confusion between the delivery of primary care through public health and through primary care services. Van Weel has suggested that *it is time to integrate personal health care and public health, and organise primary care on the principle of care for individuals in the context of an identified population over time* and that *The future of primary care, and health care in general, will depend on how effectively primary practices achieve this community-oriented primary care approach and contribute to equity and social cohesion.*[1]

This presentation will use case studies to explore this challenge from a public health perspective and the implications for future training and practice in public health.

Reference:

1. van Weel C, de Maeseneer J, Roberts R. Integration of personal and community health care. *Lancet* 2008; Sept 13:372 (9642):871-2.

#### SY15-02

##### **The Interplay of Public Health and Primary Care at the Local Level: Changhua Experience**

**Yen-Po Yeh**

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Health care utilization in Taiwan is characterized by the lack of restriction on consumers' seeking behavior. Frequent upgrades in seeking outpatient services result in the deficiency in the clear hierarchy of the medical system. Both the hospitals and the clinics provide the first-line health care for their patients, either by specialists or generalists, the so-called generalist-specialist mixing. During the past two decades, the expansion of the hospitals had put great pressure on primary care and forced the later to change. Bureau of National Health Insurance launched the Family Physician Integrated Care Program (FPICP) in 2003. The novel approach was to organize the community healthcare group as the basic unit for collaboration. However, FPICP revealed its weakness in linking other preventive services or disease management programs.

There were 478 primary care clinics (PCCs) and 27 health centers in Changhua county in 2008. Around 30% of chronic patients and 70% of the other non-chronic were cared in primary care settings. The adoption of disease management programs and preventive services was low in PCCs. The Changhua Regional Integrated Primary Care Program (CRIPCP), sponsored by Department of Health and collaborated with Taiwan Joint Commission on Hospital Accreditation, focused on the integration of related preventive services and disease management programs and also tried to scale up the range of PCCs' participation.

CRIPCP followed the "three phases, six elements" implementation process, including: the infrastructure building phase (from 2004 to 2005), the model learning

phase (from 2005 to 2006) and the care integration phase. The six elements were based on Chronic Care Model (Wagner EH., 1996), with the primary health care team (PHCT) as the core of the delivery system design. The focus areas of CRIPCP included major disease management programs (i.e. diabetes, hypertension and chronic kidney disease) and selected preventive services (i.e. adult preventive care, cancer screening and developmental screening for children). RE-AIM model (Glasgow RE, 1999) was used for program evaluation. In the early phase, there was a significant two-fold increase of the manpower of certified diabetes educators and a two-fold increase of the ratios of diabetic cases enrolled in disease management from 27% to 53%. 20% of PCCs participated the cancer screening programs. Two thirds of the primary pediatricians involved the developmental screening program for children and developed an innovation of outreach screening program for preschool children. Totally, 29% of all the PCCs in Changhua were involved in at least one of the above focused primary care programs in 2006. The percentage grew up to 40% in 2009.

From the experience of CRIPCP, we found community and policy support is indispensable for integration. However, to position clearly the physician's role in public health programs is the key for success. The inherent weakness of PCCs made the service provider's change more difficult and physicians' awareness of the need to change is the key. PHCT could support the physician's change. The linkage between the screening programs and disease management programs should be emphasized. The information system should progress from "single-user friendly" to "team-user-friendly".

#### SY15-03

##### **Arts as Assets for Primary Health Care in Asia**

**Masamine Jimba**

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According to WHO, the ultimate goal of primary health care is better health for all. To achieve this goal, WHO has identified four reforms in 2008 World Health Report: 1) universal coverage reforms; 2) service delivery reforms; 3) public policy reforms; and 4) leadership reforms. In the same report, people centered approach and their participation were also emphasized to carry out these reforms.

For people to become centered and to make active participation, empowerment is crucial. For this, assets-based approach is known to be effective. High-level medical workers, however, tend to take needs-based approach, by which they identify medical problems of individual and in a community; then, they try to help them to solve the problems. In contrast, assets-based approach seeks the potential of individual and community; then, they are expected to contribute themselves to solve their own problems. In primary health care, we need to strengthen this assets-based