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Research Article

Incorporation of Professionals with Training in Interculturality into Sexual and Reproductive Health Services: Feasibility Analysis

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This study evaluates the political, legal, organizational, and availability of resources for the onboarding of health professionals trained in interculturality for sexual and reproductive health care of the indigenous population in public health services. A case study was carried out using a qualitative methodology that implemented intercultural care strategies in reproductive health in two Mexican states with the presence of indigenous population. In regards of the political feasibility, the interest of the actors, positioning, and power were explored. In regards of legal feasibility, the presence of legal impediments was analyzed. In the case of organizational feasibility, we explored the organizational structure and functions of the personnel. Finally, for evaluating the availability of resources, we analyzed the budget available for hiring personnel with intercultural training. Political feasibility shows that the actors recognize the importance of including personnel with intercultural training for reproductive health care in indigenous population; despite this, in both states, there is no clear position in favor of it. In legal feasibility, no impediment for hiring these personnel was found. In organizational feasibility, the organizational structure of health services does not include a unit to oversee intercultural health services and practices and does not specify intercultural functions in the professional required profiles. In both states, there is no budget allocation for hiring personnel with an intercultural profile. Therefore, intercultural actions implemented are part of the local initiative of decision-makers to respond to reproductive health problems within indigenous population. The overall feasibility assessment does not show clear results in favor of incorporating health professionals trained in interculturality for sexual and reproductive health care for indigenous population. Therefore, it is still necessary to advocate on this issue so that intercultural hiring policies can be explicitly concretized in the acquisition of public health services.

1. Introduction

Mexico has a great cultural diversity originally sustained by its indigenous people and communities. In 2020, more than 7.3 million people were speakers of an indigenous language [1], and 27.5 million (21.5% of the national population) ascribed themselves as such [2]. Indigenous people in Mexico face greater socioeconomic disadvantages: in 2018, 71.9% were in conditions of poverty and 40.0% in extreme poverty, compared to 46.3% and 14.3% of the non-indigenous, respectively [3]; they double the rate of maternal and infant death; they triple the frequency of short stature in children; their life expectancy at birth is 8 to 20 years less than the national average [4]. Indigenous women systematically have lower coverage in maternal care indicators compared to their nonindigenous peers [5] and preventive services and treatment of the main forms of female cancer [6]. They face greater barriers to access, which is why they make less use of health services, and when they do use them, the care they receive is of lower quality [7], and in some cases, they are subjected to racist and mistreatment practices [8, 9]. This situation poses challenges to achieving universal

health coverage, requiring strategies to respond to the needs of indigenous populations, be culturally relevant, and address structural inequalities, especially forms of discrimination [10].

To face this problem, at the beginning of the XXI century, the Mexican Health Ministry launched the Intercultural Health Policy with four processes: (1) strengthening of the stewardship role of the Ministry of Health; (2) legal and regulatory adjustments to improve the quality of care for indigenous population; (3) operational adjustment of health programs; and (4) structural adjustments in the health system (programs, plans, norms, schedules, and organizational and management mechanisms). To monitor "intercultural" actions in health centers and hospitals, indicators related to the structure, spaces, and providers of health services were proposed. For accreditation of health units as intercultural, the number of bilingual health personnel (in indigenous language) in the health facility, human resources trained in intercultural competencies, and dissemination of programs in local language were evaluated. These indicators were also considered for sexual and reproductive health programs and were implemented in the states of Morelos and Chihuahua.

One of the most important concepts developed for bridging the cultural gap is the interculturality, which means "between cultures." Its purpose is the respectful exchange of knowledge and traditions, dialogue, complementarity, constant learning, and the primacy of a subject over cultural and social differences [11]. In health, it is defined as the respectful process of the horizontal relationship between users and health personnel, which allows understanding the way of perceiving the health-disease-care processes in each group, through dialogue, recognition, and respect for its cultural peculiarities [12, 13]. Under this concept, in order to provide health care, health workers capable to understand cultural differences in health conception on indigenous population are relevant. This strategy seems straightforward; however, its inclusion to health services has been challenging.

The proposal that must be implemented in health services should be appropriate, which means that it must respond to an existing problem in a given population and have clear objectives with strategies to achieve them, as well as the necessary resources. In this sense, the evaluation of feasibility [14] is the first step before implementing a proposal. There are several dimensions of feasibility assessment, but the most studied are the technical, economic, legal, operational, and schedule dimensions [15, 16]. Other studies indicate that feasibility assessment should provide information about the backing of political actors to support implementation, as well as a legal framework and adequate skills and capacities in personnel and an organizational structure for the appropriate use of resources [17]. Regardless of the dimensions of feasibility to be evaluated, it should provide information to analyse the possibility of success or failure of the proposal if implemented. Feasibility assessment does not necessarily assess all dimensions at the same time; it will depend on the information needed to be known according to the context where the intervention will be applied. However, the more comprehensive the assessment of the feasibility dimensions, the more information it can provide on the likely scenario of success or failure of the implementation and reduce uncertainty. This type of evaluation is a fundamental tool that supports decision-making regarding implementation of a policy, program, or project [18].

This study evaluates the political, legal, organizational, and the availability of resources of the incorporation of health professionals trained in interculturality for sexual and reproductive health care of the indigenous population in public health services. Health personnel who provide sexual and reproductive health services have a diverse profile: physicians, nurses, and health technicians. Their peculiarity is that they are in charge of providing these services, such as prenatal consultations, contraception, and women's cancer screening, among others, to the indigenous population.

2. Materials and Methods

A qualitative case study was carried out in two states of Mexico (Morelos and Chihuahua) with the presence of indigenous population and had developed initiatives for intercultural reproductive health care in 2018, particularly training allopathic medical professionals for the development of intercultural competences (knowledge of cultural differences, promotion of dignified, and respectful treatment). Intercultural training in sexual and reproductive health refers to a heterogeneous set of educational activities that address topics such as vertical childbirth, respected childbirth, and dignified treatment, among others. In the present study, we analyzed the fact of training on interculturality in sexual and reproductive health for the care of indigenous populations, regardless of its specific content.

A mapping of key informants in each state was done. The informants were contacted by telephone to invite them to participate in the study, and if they accepted, a date, time, and place for the interview were agreed upon. In Morelos, the interviews were conducted in person by AT and in Chihuahua by a female project collaborator. Interviews lasted an average of 40 to 50 minutes.

To assess the *political feasibility* [19], the interest, position, and power of the actors in the proposal to incorporate personnel trained in interculturality to care for the indigenous population were analyzed. The definitions used for these dimensions were the following:

(i) The *interest of the actors* is the expression of individual motivation for the benefit or advantage of oneself or the institution [20] that makes the implementation of strategies viable. We explored intercultural policy definition, policy knowledge, perceived importance, intercultural action, and alliances

(ii) *Positioning* is the place occupied by an individual with respect to others with whom he or she compares [21], to place him in favor or against a situation or the position of another individual.

(iii) *Power* is the phenomenon that flows from an individual to other people when functions are

delegated and responsibilities are assigned, that is, the capacity or faculty of the individual within his or her organization to influence decision-making and execute or not actions or interventions [22].

Key informants were people who work with the indigenous population and health personnel who work in the field of sexual and reproductive health (antenatal care, childbirth and puerperium care, and family planning) (Table 1).

For *legal feasibility*, it was sought to verify that there were no legal impediments to incorporate health personnel with intercultural training in sexual and reproductive health services for the care of the indigenous population. For this, a careful analysis of the legal guidelines at the federal and state levels was carried out (Table 2). All the documents were converted into PDF, and all those that included the keywords as health, indigenous, language, culture, intercultural, interculturality, human rights, traditional medicine, and discrimination were reviewed in depth. Three categories were analyzed: the right to health care for indigenous people, obligations of the authorities to care for indigenous people, and restrictions or impediments to the inclusion of health personnel with intercultural training for reproductive health care for indigenous population.

For *organizational feasibility*, we explore the organizational structure (presence of a position in the formal structure of the organization for intercultural action), intercultural functions (explicit duties to carry out interculturality actions in the organization and functions handbook), and intercultural job profile (professional profile to which the interculturality task is assigned). We check the formal and functional organizational structures to look for a unit inside the structure in charge of the intercultural actions. An in-depth review was carried out on the function manual of Ministry of Health Units related to reproductive health care (primary health facilities, hospitals, and jurisdictional and state health services) to identify interculturality functions and job profiles to perform intercultural activities. In addition, we applied interviews at the people responsible for planning, human resources, and reproductive health at jurisdictional and state levels, to explore the existence of formal structures in units and functions for health personnel linked to the intercultural policy.

For *availability of financial resources*, the state and municipal budgets were scrutinized and interviews were held with those responsible for planning, human resources, and health promotion, in order to explore the existence of resources for hiring health personnel with intercultural training.

2.1. Instruments. To explore *political feasibility,* a semistructured interview was applied that collected information on the social and demographic profile of the participants, their interests, positioning, and power [23], for the incorporation of health personnel with intercultural training for reproductive health care of the indigenous population.

The interview guide (see supplemental file 1) was piloted in a state not included in the study and was subsequently applied in the states identified for research, with the prior informed consent of the participants and approval to record. At the end of the interview with each actor, they were given a matrix so they could individually rate their position and of others (those mentioned in Table 1). The matrix also included the rating of the perceived power of each actor for the inclusion of health personnel with intercultural training for sexual and reproductive health care for the indigenous population. Before rating the different criteria included in the matrix, the interviewer explained the rating process in detail to the informants.

Specific questions were included into the semistructured interview guide, in order to explore organizational feasibility and availability of financial resources.

2.2. Information Processing

2.2.1. Political Feasibility. Although the criteria for categorizing and processing the data were determined by the research team specifically for this study, the analysis procedures are similar to those reported in other studies [24, 25].

(1) The Interest of the Actors. To measure intercultural policy definition, we explore the conception of the following categories: recognition of cultural diversity, equitable relationships, respect for differences, and mutual enrichment. We assigned +++ when actors recognize intercultural at least 3 categories, ++ when actors recognize at least 2 categories, and + when actors mention 1 or any category.

To measure the policy knowledge, we previously identified from national reports and interviews with operational staff of reproductive health services the strategies implemented. Vertical delivery, health education with an intercultural perspective, work with traditional midwives, respectful treatment of indigenous women, training of personnel in interculturality, promotion of intercultural health care, and work with agents of traditional medicine were identified as main intercultural activities. We explore if the informants know about the existence of action to address the intercultural policy. We assign +++ when actors mention at least five actions, ++ when actors mention four actions, and + when actors do not mention any or one actions.

To measure perceived importance, we assigned +++ when the actors perceived intercultural actions as essential for healthcare of indigenous communities, ++ when they considered moderately important, and + when they considered indistinct.

To measure intercultural action, we assigned +++ when they reported the execution of at least one intercultural action uninterruptedly for more than five years, ++ when they reported the execution of intercultural actions but not continuously for the last five years, and + when they recognized their recent implementation (less than 1 year).

Regarding alliances, they were rated with +++ when they recognize the participation of other actors different from the

Table 1: Key informants interviewed in each state.

Actors	Position they hold	Assigned duties
State functionaries of health services	Heads of departments (promotion, planning) Technical managers of interculturality Head of human resources	They are responsible for planning and implementing the analyzed policy
Legislators	Indigenous affairs commission Health commission	May have an impact on the implementation and legislative reforms
Operational staff of reproductive health services	Heads of health centers of indigenous communities Responsible for reproductive health care office Reproductive health services providers	Responsible for the direct implementation of the analyzed policy
Civil society organizations	CSOs related to health and indigenous people	External agents that can be an ally in the implementation of the policy
State human rights commission	Delegate	
State commission on indigenous rights (SCIR)	Technical staff	
SEDESOL	Chief Technical staff	
Community	Members of the indigenous people community	To whom the policy is directed. It may or may not accept the proposal

Source: authors' elaboration.

Ministry of Health services for more than five years, ++ when they recognize the participation of other actors intermittently for more than five years, and + when they recognize the participation of other actors recently.

(2) Positioning. We used a matrix to qualify the self-positioning and positioning of the actors, five answers were possible: in favor (F), moderately in favor (MF), neutral (N), moderately against (MA), and against (A). At a global level, positioning in favor (F) was qualified if the interviewee self-positioned in favor (F), and the other actors also qualified with the positioning in favor (F). It will be moderately in favor (MF) if the actor positions himself in favor (F), but at least one or two actors rate it as moderately against (MA) or against (A). A neutral position (N) is obtained if the actor positions himself in this way or if being in favor (F) or moderately in favor (MF), three or more actors rate him as against (A) or moderately against (MA).

(3) Power. Power was rated by assessing the actor's ability to mobilize resources. A rating of 3 was assigned if the actors consider the actor with high power, a rating of 2 for medium power, and a rating of 1 for low power.

2.2.2. Legal Feasibility. Legal feasibility made it possible to identify to what extent the legal guidelines constitute a facilitator or an impediment to the inclusion of health personnel with intercultural competencies in health services for sexual and reproductive health care of the indigenous population. The documents were analyzed by JA and AT, and a content analysis was performed. For the analysis, matrices by state were used for the dimensions of the right to health of indigenous people, obligations of the authorities, and restrictions and impediments.

2.2.3. Organizational Feasibility. We organized a matrix to record information about organizational structure, functions, and job profiles regarding intercultural activities from documents and interviews.

2.2.4. Availability of Financial Resources. The information identified in the budget reports, as well as that from the interviews, was concentrated in analysis matrices to facilitate their identification.

2.3. Ethical Aspects. After the key informants were contacted by phone and agreed to participate in the interviews, BP (as the PI of the general project) sent an invitation by e-mail, together with the letter of informed consent that they signed on the day of the interview in person.

The protocol from which this study derived was approved by the Research Ethics Committee of the National Institute of Public Health, through resolution number CI: 1475. The project was financed by the Gonzalo Río Arronte Foundation.

3. Results

In the state of Morelos, 11 key actors were interviewed from Health Services (Health Promotion, Human Resources, Planning, and Evaluation of Services), a Civil Society Organization that works with the indigenous population; the State Human Rights Commission, the State Secretariat for Social Development (SEDESOL) and legislators who lead issues related to indigenous populations. In the state of Chihuahua, 11 key actors were interviewed by the State Secretariat of Health (Responsible for regulations for the operation of health services in the state); State Civil Pensions, Health Services (Responsible for the provision of health services in the state), State Commission for Human Rights, State Commission for Indigenous Peoples, and a rural hospital. Each informant was interviewed only once, and no participant was reinterviewed.

The characteristics of the states that were included in the study are presented in Table 3.

3.1. Political Feasibility

3.1.1. The Interest of the Actors. As part of the *policy knowledge*, the development at a national level of many actions, which were implemented in other states, was recognized. In Morelos, state health professionals recognize the implementation of humanized delivery with traditional midwives, health fairs in indigenous municipalities, circles of women who practice traditional medicine, and training for health professionals and students. In Chihuahua, the actions implemented were work with native community health assistants, reproductive and vaccination, work with midwives, sexual diversity fairs in indigenous communities, intercultural courses, and translator program for indigenous communities. They also mentioned the Indigenous University Program to support indigenous youth to continue their university education.

> *". . . it is that in reality here in the state of Morelos, it is said that there is a policy of interculturality, but for me, it is only a discourse, we do not see anything concrete and everything remains on paper. . .. I-A5"*

> *". . . here [in Chihuahua] there is leadership and much recognition for the care of the indigenous population. We have had several projects to sensitize health personnel in intercultural care. . . we have implemented intercultural childbirth care and, in many programs, the educational content is revised so that the worldviews of the indigenous population are respected. . .. I-B7"*

Five actors in Morelos define the intercultural policy on health as "the cultural diversity or the necessity to respect the cultural differences to deliver health services," and they recognize the cultural diversity and the necessity to respect the cultural differences and interaction between cultures. In Chihuahua, most actors define the intercultural policy as respect for cultural differences, cultural diversity, and the promotion of equitable relationships.

Table 2: Documents reviewed at the federal and state levels.

Federal level	State level
(1) Political constitution of the united Mexican states	(1) Political constitution of the state
(2) General health law	(2) Social and human development law for the state
(3) Law of the national commission for the development of indigenous peoples	(3) Cultural development law
(4) Law of the national human rights commission	(4) Cultural heritage law
(5) Federal law to prevent and eliminate discrimination	(5) Law of professions for the state
(6) General law of culture and cultural rights	(6) Law of the decentralized public organization called the state regime of social protection in health
(7) General law on the linguistic rights of indigenous peoples	(7) State health law
(8) General law of social development	(8) Organic law of the decentralized public organization "health services"
(9) Regulations of the general health law on the provision of medical care services	(9) Law to prevent and eliminate discrimination
(10) Internal regulations of the ministry of health	(10) Law on the rights of the indigenous peoples of the state
(11) Regulations of the general health law on social protection in health	(11) Organic law of the executive power
(12) Official mexican standard NOM-007-SSA2-2016, for the care of women during pregnancy, childbirth, and the puerperium, and of the newborn (published in the DOF on April 7, 2016)	(12) Regulation of the law to prevent and eliminate discrimination in the state
(13) Mexican official standard NOM-025-SSA2-2014, for the provision of health services in comprehensive medical-psychiatric hospital care units. (Published in the DOF 4-9-2015)	(13) Internal regulations of health services
(14) Health sector program 2013–2018	(14) Internal regulations of the state health council
(15) Special program for indigenous peoples 2014–2018 (published in the DOF on 04/30/2014)	(15) Internal regulations of the Chihuahuan institute of health
(16) Agreement SO/II-12/10.01, S whereby the H. Technical committee of the national council for standardization and certification of labor competencies approves the competence standards indicated. (Published in the DOF. July 12, 2012)	(16) Internal regulations of the decentralized public organism called the state regime of social protection in health
(17) General recommendation no. 4 derived from administrative practices that constitute violations of the human rights of members of indigenous communities concerning obtaining free and informed consent for the adoption of family planning methods. (Human rights commission, published in the DOF on 12-26-2002)	

Source: authors' elaboration.

Table 3: Characteristics of the states that participated in the 2018 study.

	Morelos	Chihuahua
Total population	1,903,810	3,556,574
Percentage of indigenous population	2%	3.91%
Municipalities with an indigenous presence	18	67
Ethnic groups	Original people of the nahuas	Four native groups of people rarámuri or tarahumaras, ódami or tepehuanes, makurawe or guarojío, and finally the O'oba or pima
Marginalization index (2015)	Middle	Low
Population with health insurance (2017)	82.9	90.6
Maternal mortality ratio (2017)	21.9	43.9
Contraceptive coverage (2018)	76.39	75.45
Unmet demand in family planning	10.9	8.3

Source: national population council (CONAPO), main results of the national survey of demographic dynamics, 2014, available in https://www.conapo.gob.mx/es/CONAPO/Principales_resultados_de_la_Encuesta_Nacional_de_la_Dinamica_Demografica_2014, 28-10-2020. National survey of demographic dynamics, 2014.

Table 4: Analysis of the interest of the actors in the inclusion of professionals trained in interculturality according to power.

Actor ID	Policy knowledge	Policy definition	Perceived importance	Interculturality accions	Alliances
Morelos					
A-11	+	+	+++	++	++
A-2	+	++	+++	+	++
A-5	++	++	++	+++	+++
A-8	+	+	++	++	+
A-1	+	+	+++	+	+++
A-10	+	++	++	+	+
A-6	+	++	+	+	+
A-7	+	+	++	+	+
A-9	+	+++	+++	+	++
A-3	+++	+	+	+	+
A-4	++	++	++	+	+++
Chihuahua					
B-1	++	+	+++	++	+
B-3	+++	+++	+++	+++	+++
B-8	+++	+++	+++	++	++
B-2	++	+++	+++	+	+
B-7	++	++	+++	+++	++
B-10	++	+++	++	++	++
B-11	++	++	+++	+	+++
B-6	+	++	++	+++	++
B-4	++	+++	+++	+	++
B-5	+	+++	+++	+++	++
B-9	+	++	+++	+	+++

+++ Good ++ Medium +Poor.

"Intercultural actions for women's reproductive health care seek to respect the two worlds of knowledge, that of the indigenous population and that of the urban population. I-A6."

"Interculturality means that neither the knowledge of the indigenous population regarding their sexual and reproductive health is better or worse than the knowledge of the population in general. This knowledge is complementary and strengthens and enriches each other. I-B9"

Regarding the *perceived importance*, in Morelos State, only three of eleven actors considered intercultural health policies and inclusion of professionals with intercultural training for reproductive health care to be "very important." While in the state of Chihuahua, almost all actors considered it essential.

In Morelos State, most actors recognize the recent implementation of the *intercultural actions*, they point out this situation responds to the low proportion of indigenous population. In Chihuahua, most of the actors recognized the implementation of intercultural action more than five years ago. Some of them point out the continuity on their implementation and others their noncontinuous implementation.

In Morelos State, *alliances* were established with the education sector to carry out projects with an intercultural perspective among the State Commission of Human Rights, the Superior Court of Justice, the Commission for the Development of Indigenous People, local universities, state health services, and nongovernmental organizations. In Chihuahua State, alliances were established with the Ministry of Social Development, the PROSPERA Program, hospitals of the Ministry of Health, the Women's Institute, the State Commission for Indigenous Peoples, the Ministry of Public Education, municipal presidencies, universities, the Comprehensive System for the Protection of Children and Adolescents, the National System for the Comprehensive Development of the Family and the state governor, the secretary of health, and doctors from the private sector (Table 4).

3.1.2. Positioning and Power of the Actors. In the state of Morelos, nine out of eleven key actors positioned themselves in favor of including personnel with intercultural training for sexual and reproductive health care. However, eight actors received a different rating of positioning from the other actors that positioned them as moderately in favor or neutral. At a global level, of the eleven actors, only three were positioned in favor, four were moderately in favor, and four had a neutral position. The actors who positioned themselves moderately in favor were state´s health services who were functionaries and legislators. The actors that positioned themselves as neutral were operational personnel from the health services and a civil society organization, and those that positioned themselves in favor were from the State Commission of Human Rights, SEDESOL, and the community. Concerning the qualification of power, the actors recognized that only two have high power (state actors of health services and legislators), but none of them has a position in favor (Figure 1).

Morelos State														
Actor ID	Self-Positioning	Positioning perceived by the other actors											Global positioning	Power (AR + MR)
		A-1	A-2	A-3	A-4	A-5	A-6	A-7	A-8	A-9	A-10	A-11		
A-1	F		F	F	-	-	A	F	-	A	-	-	MF	1.5
A-2	F	-		F	-	-	A	F	-	A	-	MF	MF	1
A-3	F	-	F		-	-	A	F	-	A	-	-	MF	2.5
A-4	F	-	F	MF		-	F	A	A	A	MF	A	N	2.5
A-5	MF	A	F	MF	-		A	F	A	A	F	-	N	1
A-6	F	-	F	MF	-	-		A	A	A	F	A	N	1.5
A-7	F	MF	F	MF	-	-	F		A	A	F	-	MF	1.5
A-8	MF	-	F	MF	-	-	A	F		A	F	-	N	1
A-9	F	F	-	F	F	F	-	-	F		F	F	F	2
A-10	F	-	-	F	-	-	-	-	-	-		-	F	1.5
A-11	F	-	-	F	-	-	-	F	-	-	F		F	1
Chihuahua State														
		B-1	B-2	B-3	B-4	B-5	B-6	B-7	B-8	B-9	B-10	B-11		
B-1	MF		-	F	F	N	F	-	-	-	A	A	N	1
B-2	F	-		-	N	MA	F	F	-	-	A	A	MF	1.5
B-3	F	F	-		N	MA	F	-	MF	-	N	-	MF	1
B-4	F	-	-	F		-	F	-	-	F	-	F	F	2.5
B-5	F	-	F	F	F		F	-	F	F	-	-	F	2.5
B-6	F	F	-	-	N	MA		-	-	-	A	A	MF	2
B-7	F	-	-	-	N	MA	F		N	-	A	A	MF	1.5
B-8	F	-	-	-	N	MA	-	-		-	A	A	MF	1
B-9	F	-	F	-	N	MA	-	F	-		F	-	MF	2.5
B-10	F	-	F	-	N	-	-	-	-	-		-	MF	1.5
B-11	F	-	F	-	N	MA	-	F	-	-	-		MF	1.5

Positioning

F: In Favor
MF: Moderately in Favor
N: Neutral
MA: Moderately Against
A: Against

Power

High: 2.5 to 3
Medium: 1.5 to 2.4
Low: < than 1.5

Figure 1: Positioning and power of the actors.

In Chihuahua, nine out of eleven actors positioned themselves in favor of including personnel with intercultural training for sexual and reproductive health care. However, nine actors received a different rating from the other actors that positioned them as mildly in favor and neutral. At a global level, of the eleven actors, only two were positioned in favor, eight were moderately in favor, and one was neutral. The neutral position was held by a state health services functionary. The actors moderately in favor were an official from the state health services, operational personnel at the jurisdictional level and health units, as well as civil society organizations, SEDESOL, and the community. The actors who positioned themselves in favor were a legislator and the State Commission on Indigenous Rights. Regarding the qualification of power, the actors recognized that only two of them have high power (legislator and State Commission for Indigenous Rights) and both were in favor (see Figure 1).

Among the health personnel, one of the reasons for not decisively supporting the incorporation of personnel with intercultural training for reproductive health care in the indigenous population was because they think that these personnel can only be of indigenous origin and have doubts about their capacity to provide care and; therefore, there would be work overload for other health professionals; they were only in favor of staff with intercultural skills (it means indigenous people) assigned only to health promotion actions.

> *"We are not sure that doctors of indigenous origin [indigenous people who study medicine] or with a specialty in traditional medicine, have the preparation and empathy to care for the indigenous population. I-A2"*

"[One option would be for] doctors of indigenous origin to dedicate themselves to give talks and carrying out actions to promote health, this work is so heavy, since the concept of health disease has different explanations for the indigenous population. I-B2"

The evaluation of political feasibility to include health personnel with intercultural training for sexual and reproductive care does not show a favorable scenario in any of the states studied, even though many actors recognize the importance of their inclusion.

3.2. Legal Feasibility

3.2.1. Health Right. The right to health protection is contemplated in Article 4 of the Political Constitution of the United Mexican States (PCUMS) and declares that "every person has the right to health protection." The General Health Law regulates this right and establishes the bases and modalities for access to services, as well as the concurrence of the Federation and the states in matters of general health.

Paragraph B of Article 2 of the PCUMS also establishes that "to reduce the shortcomings and lags that affect indigenous people and communities" (. . .) "effective access to health services will be ensured by expanding the coverage of the national system, duly taking advantage of traditional medicine" [26]. The Federal Law to Prevent and Eliminate Discrimination prohibits limiting access to medical care for the indigenous population for reasons of discrimination (article 9, sections VII and XXI). However, the Law of the National Commission for the Development of Indigenous Peoples does not specifically address the right to health of indigenous people.

The Political Constitution of the state of Morelos recognizes the indigenous communities, their language, culture, and historical rights and delegates to the authorities the organization of mechanisms and procedures to guarantee effective access to health care, taking advantage of the development of traditional medicine (Article 2 bis). The Political Constitution of the state of Chihuahua recognizes the right of the indigenous population to use and develop its traditional medical system, as well as to care in public health services (Article 155). The State Health Law protects the right to traditional practices for the prevention, diagnosis, or treatment of physical or mental illnesses (Article 85); the incorporation of traditional forms of healing (Article 240, section III); and the design, implementation, and execution of programs that promote knowledge, protection, development, and use of traditional medicine (Article 14).

3.2.2. Obligations of the Authorities. The Mexican Constitution establishes that the federation, states, and municipalities must ensure effective access to health services for indigenous people, "taking due advantage of traditional medicine" (Article 2, Subsection B, Section III). The General Health Law establishes that the objectives of the National Health System include "promoting the well-being and development of indigenous families and communities" (article 6, section IV Bis.) and "promoting the knowledge and development of traditional indigenous medicine and its practice in adequate conditions" (article 6, section VI Bis and article 93.) and point out the maternal and child nutrition program in indigenous people and communities is a matter of general health (article 3). Likewise, "the Ministry of Health will promote the participation in the national health system (. . .) of the authorities or representatives of the indigenous communities" (article 10). Also, the social assistance to indigenous communities is considered a basic health service (article 27, section X) for indigenous users "will have the right to receive sufficient, clear, timely, and truthful information, as well as the necessary guidance regarding their health and about the risks and alternatives of the diagnostic, therapeutic, and surgical procedures that are indicated or applied" (article 51, bis 1). The information and educational guidance on family planning should also be carried out in the native languages in use of indigenous communities (article 67) that the authority must support indigenous people to file complaints, claims, and suggestions on the provision of health services (article 54). The "primary care programs that are developed in the indigenous communities must adapt to their social and administrative structure, as well as to their conception of health" (article 93). The indigenous authorities must participate in the generation and processing of health information for planning, programming, budgeting, and control purposes (article 104) in epidemiological surveillance activities (article 393) and in health security measures (article 403).

The General Law on the Linguistic Rights of Indigenous Peoples establishes that the State must guarantee that public institutions, dependencies, and offices have personnel with knowledge of indigenous languages (article 13, section XII). The Official Mexican Standard "NOM-007-SSA2-2016" states that prenatal control activities must be carried out "with cultural relevance," especially when serving indigenous women (number 5.3.1.16); in second-level units in indigenous regions, the presence of intercultural facilitators (indigenous translators) should be promoted to support the care of pregnant women and ensure understanding of the procedures to be carried out as an essential element (paragraph 5.11.13.15) and care during pregnancy, childbirth, puerperium, and the newborn must be provided concerning the dignity and culture of the users, and low-risk births can be attended by technical and traditional midwives (paragraph 5.1.11).

The Law for the Promotion and Development of the Rights and Culture of the Communities and Indigenous Peoples of the State of Morelos establishes the obligation of the health services to guarantee the effective access of the indigenous people and communities to them, stipulating that the personnel have basic knowledge of the language, culture, and customs (Article 80). The State Health Law in the state of Chihuahua establishes that the orientation and procedures for indigenous populations or communities regarding their health will be in Spanish or the language used in the community (Article 53), as well as to receive information on their reproductive health (Article 62). The State Commission for Indigenous People must train and

professionalize translators, train the staff of government institutions on indigenous cultures, and incorporate indigenous professionals into their government agencies to carry out projects and programs in indigenous communities (Article 35, Sections VII and XIV).

3.2.3. Restrictions and Impediments. None of the elements of the legal framework analyzed were restrictive or considered impediments to carrying out the initiative proposed here. The rest of the documents reviewed did not show important results associated with the subject of study.

In general, the legal feasibility evaluation recognizes the legal framework and establishes the bases and modalities for health access, and we did not find any regulation or legal impediments that forbid the inclusion of health personnel with intercultural training for sexual and reproductive care.

3.3. Organizational Feasibility

3.3.1. Organic Structure. In the review of the organizational structure of the Health Services of Morelos, the State Health System of Chihuahua, hospitals, and primary care units, no directorate, department, or headquarters was found to be responsible for implementing the intercultural strategy. The interviewees confirmed that they do not recognize the existence of a position at health units of the health system for the implementation of the intercultural policy for health care.

"Many functionaries talk about interculturality and recognize the necessity to have a person in charge of these activities, but in practice there is no position within the organizational structure of health units that supports this claim. . .. So, we don't have money to pay them. IB-8"

3.3.2. Functions regarding Intercultural Actions. In the function's manuals of the health services of both states, in positions of directors, department heads, and operational staff, no functions were specified to implement the intercultural actions. However, the interviewees responded that the interculturality is transversal and all managers and operational health personnel must implement it. They also pointed out that the Health Promotion Directorate is functionally recognized as responsible for implementing intercultural actions since interventions in the community and social determinants of health are nested in this unit.

"Ethnicity is a determinant of health, which is why those in charge of implementing the intercultural strategy are the State Health Promotion Department. I-A10"

3.3.3. Job Profile. In none of the states, a job profile was found to implement intercultural actions and none of the interviewees recognized a specific job profile to implement these actions. However, the interviewees considered nurses, promoters, or other personnel who speak an indigenous language, have the perfect profile to perform intercultural actions, but these personnel do not have a contract that specifies these functions.

"No, although the promoter carries out all that, in fact, she does not even have the promoter code, even though she signs as such. We have translators, the promoter, and the pharmacy staff speak the local language and are the ones who carry out activities with the indigenous population. A-9"

In terms of organizational feasibility, we did not find a position and functions within the organizational structure that would allow for the inclusion of health personnel with intercultural training in sexual and reproductive health care.

3.4. Availability of Financial Resources. In the state of Morelos, a functionary stated that he had some resources for the implementation of the intercultural policy; however, he pointed out that the budget for hiring personnel with this profile is not foreseen. In Chihuahua, three functionaries at the strategic level were willing to commit part of their budget to the intercultural policy; however, they point out that the resources are scarce and not sufficient to hire personnel with this profile.

"The budget is labeled and there is little flexibility for spending, it is necessary to consider this resource during budget planning so that it comes labeled and staff with this profile can be hired. I.B-12"

On the other hand, the Popular Health Insurance (its purpose was to provide protection to the poorest population, who had no insurance scheme, through a public and voluntary health insurance scheme) was recognized as a possibility for building intercultural bridges because through the voluntary insurance payments, a payment was provided to the traditional midwives, who are the link with the indigenous community (the bridge). The intercultural bridges are a strategy of the health services to establish better communication with the indigenous population. The functionaries specified that the proposal for financing personnel with this profile (with intercultural competencies) must be made in each state. In Chihuahua, health assistants (people from the community) receive a compensation ranging from 400 to 1,300 pesos per month (between 20 and 64 dollars), but they do not have a formal contract. In Morelos, community health agents do not receive any salary, their work is totally voluntary. This implies that they have no obligations in health clinics; however, some units they follow up on the volunteers' actions are performed but still under no contractual obligations.

A Functionary Mentioned:

"the new personnel [referring to indigenous people from the communities] should even earn a little more than the mestizo personnel, considering that they are bilingual or that they could attend to the population in consultation and even go out into the field."

4. Discussion

The political feasibility analysis shows that, at least in the discourse, all actors involved showed a position in favor of hiring personnel with intercultural training to deliver sexual and reproductive health services. However, the position valued by other actors is confronted with the result of self-positioning and tends to reduce the result in favor, and globally, open opponents are not identified. This result is expected since interculturality is a topic of contemporary political discourse with which few people can publicly disagree, but the real challenge is to translate that interest into concrete actions [27]. Overall, analyzing the political positioning, it can be recognized that the political feasibility does not have a resounding rating in favor because the majority of actors position themselves as moderately in favor. This work does not allow us to identify the reasons why there is no strong position in favor of a hiring policy for personnel with intercultural training. However, this issue will have to continue to be explored by government functionaries.

Regarding legal feasibility, no impediment of this nature was found for the hiring of personnel with intercultural training. The current regulations implicitly assume that interculturality only refers to the merely cultural, such as language, but none of the documents reviewed recognize the structural determinants of inequalities such as poverty and marginalization in which most of the indigenous population live. Thus, the problem is attributed to the cultural difference and not to structural inequalities. The statement in article 51 bis 1 of the General Health Law stands out regarding the fact that indigenous people have the right to receive pertinent information in their native language. The framework of interculturality behind the policy is very tight, and the government needs to strength the laws considering the concept of cultural safety [28]. Also, the law does not specify how the intercultural policy will be implemented, who is the guarantor, and through what instruments and assumptions. Consequently, due to the unclear nature of the policy and its implementation, indigenous population face multiple barriers in accessing health care, as a result of the structures that produce inequality, particularly discriminatory and racist ideologies [29]; aspects that any policy committed to equity, such as interculturality in health, should consider identifying actions that allow these conditions to be transformed [30].

There being no legal impediments to the incorporation of professionals with intercultural training for reproductive health care, we assume that the obstacles are represented by the people themselves who see "intercultural" as a synonym of traditional medicine or indigenous people, in a culturalist logic, as evidenced by the testimonies and official documents that were reviewed in this study. From this perspective, interculturality can be thought of mainly as the adoption of "folk" elements in health services, rather than the competencies and skills of dignified and respectful treatment that all health personnel should develop for an adequate approach to the community population, especially actions that prevent or confront the assessment and practices of discrimination, racism, and mistreatment towards the indigenous populations in sexual and reproductive health services. Indeed, this is the approach to interculturality assumed by the authors, one that not only recognizes cultural differences but also takes into consideration structural inequalities and structures that reproduce them, specifically discriminatory ideologies such as racism.

Weak organizational support has been observed [31] that formalizes the implementation of intercultural policy and, with it, the hiring of personnel with intercultural training. This is expressed in the absence of a specific job profile, organizational structures, and responsibilities of functionaries, managers, and operational staff to implement intercultural strategies for health care of indigenous populations [32]. The lack of availability and budget provision for hiring of health personnel with intercultural training for reproductive health care of indigenous population has also been evidenced, despite recognizing the presence of the indigenous population in their territory and their disadvantages in access to health services. This issue of budget availability is a very sensitive indicator since the budget and its items are managed within each state. Decentralization of health care supports the capacity of states to move towards building an organizational structure and occupational profiles in favor of intercultural care, as well as to allocate budgets. This requires that health policies have a strong bias in favor of equity and dignified services [33].

Finally, there is a clear need to have personnel with intercultural training for the care of the indigenous population [34, 35] since the evidence shows the health workers trained in interculturality improve knowledge, attitudes, and confidence [36] and establish better communication and a more effective health care [37, 38]. However, special attention should be paid to the operating personnel of the health centers since they are the ones who expressed the greatest disagreement with the possibility of hiring health personnel with intercultural skills. Although the focus of the study was on allopathic professionals with intercultural competencies, they rejected this possibility and this reluctance could be linked to prejudices from their notion of interculturality, which is mainly associated with traditional medicine, and this assumes that staff with intercultural skills can only be indigenous people. This shows the need to work more around this notion, which should be clearly defined and overcome the narrow conception that relates it exclusively to the culture without considering other aspects such as structural inequalities [30]. Another aspect that stands out from the testimonies is the idea that indigenous people trained in allopathic medicine probably do not have the sufficient skills to provide quality medical care and that their work should be restricted to health promotion activities. These ideas can veiledly express the discriminatory assessments of indigenous people trained in the field of medicine. At the same time, it highlights the absence of questioning by the functionaries and providers interviewed, which points the structural analysis of health inequalities that affect indigenous populations, especially forms of discrimination, mistreatment, and racism [4, 5].

4.1. Limitations. We developed this study only in two states with different marginalization indexes, middle and low; Morelos is a small state, with better access conditions; Chihuahua is a big state with more complicated access conditions. Despite this fact, these characteristics are specific to the context and not to the study design. The results cannot represent the same feasibility for incorporation of health professionals with training in interculturality for sexual and reproductive health care of the indigenous population for others contexts, even with similar marginalization index, because perceptions and interests could be specific and different.

On the other hand, the fact that the intercultural health policy in Mexico has different strategies, such as vertical attention to childbirth, the incorporation of traditional doctors or translators in indigenous languages makes its evaluation more complex. We decided to evaluate only the availability of personnel trained in interculturality in the framework of sexual and reproductive health services directed to indigenous populations but not delving into the specific characteristics of the training content.

5. Conclusion

The evaluation of global feasibility does not show results clearly in favor of the incorporation of health professionals with training in interculturality for the care of the sexual and reproductive health of the indigenous population. At the political level, the actors showed a moderately favorable position, and no guidelines were found that prohibit the inclusion of personnel with intercultural training for sexual and reproductive health care. At the organizational level, the health institutions do not contemplate a unit or professionals to implement the intercultural policy and there is no budget for hiring health personnel with intercultural training for reproductive health care for the indigenous population. The outlook is not encouraging, especially in a country such as Mexico with great cultural diversity and a large presence of indigenous population; therefore, it is still necessary to generate evidence to influence this issue, so those intercultural policies can be explicitly concretized in the supply of public health services.

The study results of feasibility are unique for a specific context since the social actors have particular knowledge, beliefs, and political affiliation that determine their behaviours to support or not the implementation of policies and programs. We emphasize that feasibility studies prior to the implementation program or policy in Latin America are scarce despite their importance in providing information to decision-makers in order to support a pertinent proposal implementation. In general, this study has a similar methodology to other feasibility studies, but the criterion is specific to this topic and can inspire the development of similar studies in other programs and contexts.

Data Availability

The data used to support the findings of this study are available from the corresponding author on request.

Additional Points

What is known about this topic? (i) Indigenous populations face barriers to accessing health services, language being the main one. (ii) Health care personnel trained in interculturality is an affirmative action that improves the quality of care. (iii) Empirical evidence is scarce regarding the feasibility of incorporating these professionals in health services. *What this paper adds*? (i) The official notion of interculturality is limited and is reduced to a culturalist view. (ii) The incorporation of health professionals with intercultural training in sexual and reproductive health care services does not have a clear priority among decision-makers. (iii) The organizational elements of the health care services and financial aspects are the main limitations for the incorporation of interculturality-trained personnel.

Conflicts of Interest

The authors declare that they have no conflicts of interest.

Authors' Contributions

JA designed the proposal, conducted the interpretation of data, wrote the first draft of the manuscript, and approved the submitted version. BP revised the interpretation of data, wrote the first draft of the manuscript, and approved the submitted version. SM revised the manuscript critically and approved the submitted version. AT conducted acquisition and interpretation of data and approved the submitted version.

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Supplementary Materials

Supplemental file 1 contains the instruments used in this study. (*Supplementary Materials*)

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