OUT OF SIGHT, OUT OF MIND:

INTERCULTURAL NURSE TECHNICIANS IN THE PERUVIAN AMAZON

by

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This dissertation assesses the complexity inherent in the use of the concept of *interculturalidad* to implement projects and policies for indigenous people. The research is based on a case study of a grassroots initiative in intercultural health promoted by AIDESEP, an organization that represents indigenous communities from the Peruvian Amazon. The findings demonstrate the limitations of the strategies of both the indigenous organizations and the state around intercultural health and the creativity that, despite these limitations, a group of indigenous nurse technicians use to provide intercultural health care.

Interculturalidad does not have a single static meaning; rather, its meaning is specific to the context and actor using it. Two different meanings of *interculturalidad* are discussed in this dissertation, Critical and Functional *interculturalidad*. Critical *interculturalidad* is the one usually used by indigenous organizations which aim to effect changes to policy-making processes that have historically marginalized indigenous people and their knowledge. On the other hand, the state's use of *interculturalidad* is often limited to a superficial acknowledgement of cultural difference without questioning root causes of discrimination against indigenous people during policy-making. This is known as Functional *interculturalidad* and, in contrast with Critical *interculturalidad*, does not aim to make radical changes in indigenous peoples' social

position. In this dissertation I show that beyond discussions about the meaning of *interculturalidad,* intercultural policies require flexibility from bureaucratic state structures, and openness for negotiation on behalf of indigenous organizations.

Through the analysis of the approaches used by the Peruvian state and AIDESEP to provide intercultural health in Peru, this research shows that without structural changes in the state's support and promotion of indigenous medicine, intercultural health will only produce superficial changes. Furthermore, this dissertation shows that without active political support from indigenous organizations, changes in healthcare delivery for indigenous people will remain limited. In the context of health services for indigenous communities in the Peruvian Amazon *interculturalidad* remains a well-intentioned idea, yet its implementation in health care by indigenous organizations and the state falls short of delivering the transformation it seeks to promote.

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ACRONYMS

AIDESEP	:	Asociación Interétnica de Desarrollo de la Selva Peruana.
CENSI	:	Centro Nacional de Salud Intercultural
IK	:	Indigenous Knowledge
INT	:	Intercultural Nurse Technician
MINSA	:	Ministerio de Salud
MoH	:	Ministry of Health
NORDECO	:	Nordic Agency for Development and Ecology
PAHO	:	Pan American Health Organization
PFETSIA	:	Programa de Formación de Enfermeros Técnicos en Salud Intercultural Amazónica
PHC	:	Primary Health Care
PSI	:	Programa de Salud Indígena
SIS	:	Seguro Integral de Salud
SERUM	:	Servicio Rural y Urbano Marginal
TM	:	Traditional Medicine
WHO	:	World Health Organization

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comments were insightful and thought-provoking, and helped me be careful to think about the risks of focusing on the recognition of indigenous medicine as a core element to reduce health inequalities.

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I am thankful to the Inter American Foundation for providing me with a Grassroots Development Fellowship that allowed me to conduct twelve months of fieldwork in Peru and granted me the opportunity to exchange ideas about grassroots development with other fellows and university professors at the IAF Mid-Year conference in February of 2011 in Guatemala.

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I do not have words to express my gratitude to all the Intercultural Nurse Technicians who hosted me during my fieldwork. They willingly shared their home, food and everyday lives at the local health facilities. Their openness in sharing their stories and describing the challenges they faced in using an intercultural approach to health care, and their critical assessment of their own efforts, was invaluable for my research. I hope this dissertation will contribute in institutionalizing some of their innovations in the delivery of health care for indigenous people. My warmest thanks go to every single Intercultural Nurse Technician and their families.

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PREFACE

Writing about the intercultural health program of AIDESEP from an academic standpoint was not an easy endeavor. I had known the Intercultural Nurse Technician's project and many of the people involved in it for several years even before beginning my Ph.D. program. I was a close friend with people who were part of the project and I shared with them their illusions and expectations about improving health care for indigenous people.

Thus, it was challenging to take a critical stance towards AIDESEP's program goals and strategies. It took me 270 pages and recurring comments from my committee members to be able to realize the disconnection between AIDESEP's political goals and the health care demands of indigenous people at the local level. As I re-read the final draft of my dissertation, it became apparent to me that AIDESEP's Indigenous Health Program's goals to have indigenous medical knowledge recognized by the Ministry of Health differed from indigenous peoples' concrete demands around health care. Rather than arguing for health services that were culturally appropriate and that incorporated indigenous medical practices, people in the communities I visited demanded reliable availability of medications and permanent staffing of health posts.

As an indigenous organization structured around political goals, issues of identity and ethnicity are central to AIDESEP. However, when such goals are articulated through a health program such as the one analyzed in this dissertation, it becomes apparent that improving the

health status of indigenous people requires social and economy strategies as much as political claims around cultural recognition.

I do believe that indigenous people deserve better health services than the ones they currently have access to. Like my friends and colleagues at AIDESEP's Indigenous Health Program I also believe that the use of an intercultural approach is part of the solution. However, it is also important to recognize that public health measures and improved socio-economic conditions will have a – greater impact – on the health status of indigenous people than intercultural health, and one must be careful to not overemphasize the role of the latter.

1.0 INTRODUCTION: INTERCULTURALIDADES AND HEALTH CARE

Interculturalidad is currently a popular concept in Latin America. It is an influential political discourse that has grown stronger since the 1980s (Del Cairo Silva 2012). Interculturalidad is a complex and fluid concept that gains meaning in specific contexts and vis-à-vis specific actors (Sartorello 2009). Government officials and policy makers use interculturalidad to show their openness towards the diversity in their countries. Intellectuals conceive interculturalidad as a revolutionary term that reverts decades of marginalization of indigenous peoples with the promise of radical changes in governmental structures and ideologies (Tubino 2005; Walsh 2006; Viaña 2010). Indigenous organizations see interculturalidad as an idea that could reframe the ways their organizations interact with the State, using the idea of interculturalidad as a tool to gain cultural recognition and respect as indigenous citizens (Yashar 2005; Postero 2007). It is ironic there are so many different ways of using and conceptualizing interculturalidad because the goal of such a term is precisely "to be a bridge between groups holding different understandings, meanings and views" (Ruiz 2006:198). Interculturalidad is meant to be a term that can transcend cultural differences without creating further misunderstanding, discord and ambiguity.

The focus of my research in this dissertation is a health initiative promoted by the indigenous organization "AIDESEP" (*Asociación Interétnica de Desarrollo de la Selva Peruana*). The goal of such initiative is to provide intercultural health care to indigenous

communities in the Peruvian Amazon and promote structural changes in the way governmental health services respond to the health needs and cultural characteristics of indigenous people. I focus on AIDESEP's strategy to foster an intercultural approach to health care from within governmental health facilities,[1] using indigenous health professionals educated in both indigenous and Western medicine. The efforts of these health professionals who hold a technical degree as Intercultural Nurse Technicians (INTs) are the core of this research.

My case study shows the shortcomings of interculturalidad as a concept used to design interventions aimed at the reduction of health inequalities between indigenous and non-indigenous Peruvians through the stress on cultural recognition. The recognition of indigenous medical practices is a relevant political argument for AIDESEP and it is at the center of its indigenous health program. However, as I will show in the following pages, it has only managed to achieve small-scale successes. People who live in the communtiies served by INTs are certainly receiving better health services by having health workers that do not discriminate against indigenous people and their cultural practices. Nevertheless, my results suggest that such successes will not transform healthcare delivery for indigenous communities if the larger structures that reproduce social, cultural and economic discrimination (within the health sector and the Peruvian society) against indigenous people remain in place.

Central to the reasons behind AIDESEP's limited success are the discrepancies between AIDESEP and the MoH's efforts to promote intercultural health. Although both institutions argue that they want health services to be more culturally appropriate, their rationales are different. While the MoH understands intercultural health as a strategy to attract indigenous

[1] Governmental health facilities are facilities funded by the Peruvian Ministry of Health through public funds. They are meant to provide services to Peruvians whose income or employment condition does not make them eligible for the Social Security Health System (ESSALUD). Governmental health facilities are usually the only medical care available in the poorest areas of the country.

people to the health services and increase their access to health care, for AIDESEP intercultural health requires the cultural recognition of indigenous medicine. As my research findings demonstrate, both approaches are based on pre-conceived ideas about the needs of indigenous people “on the ground”. What I found was that indigenous people do not frame their demands in terms of cultural competence or intercultural health services and that both the MoH and AIDESEP need to listen to people’s concrete needs in order to design more responsive interventions.

Both the MoH and AIDESEP claim to be concerned about the persistent health inequalities experienced by indigenous people yet, as my study shows, neither of them explicitly question the social determinants of health that are at the root of most health problems experienced by indigenous people. Both approaches to intercultural health have a curative rather than a preventive approach which has shown to be more effective in the reduction of morbidity and mortality.

Needless to say, intercultural health approaches per se will not solve the health problems that derive from poverty and exclusion. However, the thrust for health services that are tailored to the cultural characteristics of indigenous people addresses at least one component of exclusion: discrimination based on the patient’s ethnicity. A more radical conceptualization of interculturalidad is lacking in AIDESEP’s effort, one that will stress the importance of demanding increased political participation in policy-making for indigenous organizations. Interculturalidad requires the development of “equitable processes through which (…) marginalized groups can gain a seat at the table- and stay at the table, having a real voice in decision making affecting their lives.” (Minkler 2010:81).

My original research questions did not contemplate a nuanced discussion of structural problems that explain the health disparities that affect indigenous people. Rather, my research interest was about the political capacity of indigenous organizations to achieve health policy changes through the training of intercultural nurse technicians. Using the work of INTs in health facilities in Atalaya (a province in the Eastern Peruvian Amazon) as a case study, I proposed the following research questions:

(1) How do definitions of interculturalidad and intercultural health proposed by the Peruvian State and AIDESEP translate into health service provision in the Peruvian Amazon?

(2) Are the strategies derived from those definitions being translated into a supportive environment for INTs intercultural health efforts?

(3) What are the challenges faced by INTs to incorporate an intercultural approach in services currently provided at primary health care facilities in the Peruvian Amazon?

(4) To what extent can INTs intercultural health efforts represent the beginning of a transformation of health services for indigenous people?

In discussing the challenges of incorporating an intercultural approach in primary health care facilities, I show that AIDESEP's strategy of promoting policy-level changes through nurse technicians is not succeeding. I found that intercultural nurse technicians held little or no power at health facilities; that their opinions were overlooked by health professionals who held a higher academic degree, belonged to more privileged sectors of the Peruvian society; and have not been trained in intercultural health. In such a context INTs efforts remained hidden or neutralized.

Interculturalidad remains a well-intentioned idea that falls short of delivering the transformation it seeks to promote, on the one hand because those in charge (i.e. INTs) are left alone, without AIDESEP's backing to implement an intercultural approach in Primary Health Care (PHC). And on the other, because the transformative discourse of interculturalidad has not penetrated structural levels of the health sector and remains a discursive tool.

As I will show in the dissertation, both AIDESEP (Chapter 2) and the MoH (Chapter 3) promote the importance of using an intercultural approach to improve health services for indigenous people. Their support can be seen in references made to interculturalidad in official documents and regulations, and from comments about the importance of promoting interculturalidad made in interviews with leaders and health authorities. However, neither AIDESEP's leaders nor health authorities use their political leverage to ensure that intercultural health efforts materialize or develop beyond the changes introduced by INTs. One explanation is that, despite AIDESEP's efforts indigenous communities do not perceive culturally appropriate health services as a priority and rather, have more concrete demands such as more medications and permanent health workers.

AIDESEP's strategy has focused on designing and implementing an educational project to train indigenous youth in intercultural health, but has failed to offer the necessary political support for scaling-up their efforts. Thus, the impact of INTs efforts remain bounded to the communities they are currently working in. AIDESEP's concern in strengthening indigenous cultural traditions and advocating for the recognition of indigenous healers who use indigenous medicine are only occurring on a small scale. Despite the official discourse about embracing intercultural health, the MoH is not paying attention to INTs efforts, nor granting the legal and administrative support for using an intercultural approach in health services.

My dissertation shows that the MoH does not provide the necessary flexibility to enable health workers to combine Western and Indigenous medical approaches when providing health care. Combining both medical traditions in a horizontal way is one core characteristic of intercultural health efforts. Indigenous healers remain marginal to the official health system, and medicinal plants have to be used out of the sight of health authorities. Despite INT's training in both medical systems, as nurse technicians they occupy a lower level of power within the structure of the health system. INTs suggestions are not always taken into account when it comes to adapting services to better serve indigenous people according to their ways of life. Furthermore, the MoH expects INTs to follow the mandates according to biomedical standards. Whenever INTs stray away from conventional medical standards to heal a patient using indigenous medicine, they tend to hide such use or just not report it. Health services thus, remain unchanged. Indigenous medical traditions continue to provide parallel medical care and yet, remain ignored by the official health system.

Throughout this dissertation, I describe the everyday activities of INTs working at governmental health facilities. I analyze their efforts and contrast them with AIDESEP's and the MoH's official positions on intercultural health and the strategies proposed to implement it. Central to my analysis was identifying the support AIDESEP was providing to INTs to scale-up intercultural health interventions, and the role AIDESEP's political capital was playing in ensuring health services for indigenous people was indeed culturally appropriate. My goal was to illustrate the possibilities of providing intercultural health in the Peruvian Amazon, and also the challenges of implementing a concept such as interculturalidad into a concrete situation: health care provision. My dissertation shows that intercultural initiatives ought to be met by both political will and administrative structures that enable such initiatives to change public services.

Furthermore, the examples collected in the field regarding the opportunities and limitations for using an intercultural approach by INTs show that indigenous nurse technicians have to overcome discrimination as indigenous people and as nurse technicians from their co-workers to be able to openly advocate for intercultural health. Paraphrasing Lasker and Gudiry (2009), if we want to fulfill the promise of interculturalidad "we need to be less content with giving historically excluded groups influence at the margins and work to create processes that give them influence that counts" (p.218).

The examples collected in the field regarding access to health care for indigenous people also raises the question of whether the right to water, sanitation, schooling and sustainable livelihoods ought to be a priority in the agenda of indigenous organizations, rather than intercultural health and the recognition of indigenous medicine. Using the cultural recognition of indigenous medicine as a central tool for reducing health disparities can overshadow broader social and economic needs of indigenous people that are at the root of health disparities.

1.1 INTERCULTURALIDAD IN LATIN AMERICA

Interculturalidad has become a popular concept in Latin America since the 1990s. Among other reasons, interculturalidad represented a response to the increased need to promote positive relations between different cultural groups within Latin American nations and to confront discrimination, racism and exclusion (Walsh 2006). Interculturalidad represents a consolidation of democratic ideas about the new relationship between indigenous people and the non-indigenous broader society in Latin America. Interculturalidad responds to the need of forming citizens who are conscious of the differences between each other but who are able to work

together for the development of their country and in the construction of a fairer, egalitarian and plural democracy (Walsh 2000).

Ideas about interculturalidad have taken various shapes in Latin American countries. For example, in Ecuador, discourses around interculturalidad were developed by the indigenous movement in opposition to political hegemony over knowledge production; interculturalidad was an ideological proposal to open the state to other ways of thinking about democratic practices and cultural difference (Ramírez Hita 2009). Interculturalidad in Ecuador has provided indigenous organizations with a conceptual framework that stresses the importance of recognizing the value of indigenous knowledge as a crucial step for challenging the historical subordination of indigenous people (Johnson 2010; Viaña 2010).

In Bolivia, interculturalidad has become one of the pillars of strategies for state decolonization and transformation. For example, Johnson explains how "A simple and often-quoted definition of the term identifies the integrated relationships between persons or social groups of diverse cultures or worldviews and, by extension, the attitudes of bearers of one culture toward the elemental norms of another" (Johnson 2010:141). In both the cases of Bolivia and Ecuador, indigenous social movements have embraced interculturalidad as a political project. They promote interculturalidad as a means to transform the modern state and to create "a plurinational state that recognizes the diversity of its people" (Yumbay 2002:13).

Walsh (2005) and Tubino (2005) stress that interculturalidad – at least in Ecuador and Bolivia – has been at the basis of indigenous organizations' demands of having social policies transform power relations between two systems of knowledge and two sets of people. Such authors argue that when indigenous movements use the concept of interculturalidad, they have both political and social goals to attain. For Yashar (2005), indigenous movements in Latin

America “are demanding equal rights; but they are also demanding recognition of special rights as native people” (pg.5). This dissertation examining the promotion of intercultural health approaches in the Peruvian Amazon shows that changing social policies from below require not only a bottom-up effort from indigenous organizations but also responsiveness from the State.

AIDESEP’s Indigenous Health Program (PSI) aims at strengthening indigenous medical systems and improving health care provision for indigenous people by training indigenous youth as intercultural nurse technicians who will use both indigenous and western medicine to address the health problems of indigenous people. The nurse technicians trained by AIDESEP are expected to work at governmental health facilities and promote changes from within. Placing on the intercultural nurse technicians the responsibility of transforming health services at the regional level is an ambitions and –as I will show– unrealistic goal. It overlooks that their suggestions are often not taken into consideration by health professionals with higher academic degrees from more prestigious educational institutions, and who tend to view indigenous people as less smart than *mestizos*.

As a result, despite the AIDESEP PSI’s broader expectations of transforming power relations between two systems of knowledge and changing the way indigenous medical practices are perceived by the health sector, fail. The changes I was able to observe are minor, restricted to the level of health care provision by the AIDESEP- trained INTs. Even at the regional level, health professionals during my time in the field continued to perceive indigenous medical practices as useless, at best, and mostly negative for health.

In as much as interculturalidad challenges consolidated hierarchical relationships between social groups, it “is not a smooth, let alone automatically successful process” (De La Cadena 2006:219). For indigenous organizations, interculturalidad is an ambitious and radical

project that “aims at forging a world characterized by “pacific cohabitation among peoples and cultures, based on justice and equality for all” (Menchú 1998:13). Ideally interculturalidad is process that should occur in an environment of respect, reciprocity, and honest exchange of beliefs and practices, resulting in mutual growth, enrichment, and transformation (Albo 2004). The question that my dissertation raises is whether governmental structures –such as health services– can make room for new approaches, like interculturalidad, which demand that both professionals and bureaucratic structures become open and accepting of indigenous medical systems.

In order for intercultural approaches to health care to be taken seriously and recognized as improvements in health care provision, more support needs to be given to the small, community level accomplishments of AIDESEP INTs. For interculturalidad to hold ground and transform wider aspects of the health sector, indigenous organizations ought to ensure the minor successes they attain are recognized by the health sector and officially promoted in other places. Just focusing on training health professionals is certainly not enough to change a monocultural health system into an intercultural one. This should also be a lesson for the guidelines that are issued by the Peruvian MoH regarding interculturalidad. The MoH also stresses the importance of having “culturally competent” health workers and ignore that bureaucratic structures ought to change to provide opportunities for such health workers to use an intercultural approach.

There are two important aspects to highlight in the cases of Bolivia and Ecuador in terms of transforming governmental structures. One is that the ideal of interculturalidad was born at the grassroots level, and in the case of Bolivia interculturalidad became official policy once Evo Morales reached power in 2006. This is not the case in every country. For instance, in Peru the most widespread version of interculturalidad is that of a state project defined as a “dialogue

among cultures" (Godenzzi 2001). Interculturalidad in Peru is often viewed as a state project. One example is the creation of the Vice ministry of Interculturalidad in 2011.

AIDESEP's intercultural health project aims at transforming governmental health services from below (rather than through state mandates) through new ways of conceiving health services that respond to indigenous organizations' demands. State-promoted interculturalidad on the other hand does not necessarily reflect indigenous organizations' expectations but, rather, what the state interprets to be their expectations. Nevertheless, grassroots efforts such as the one I describe in this dissertation needs to be met by governmental structures that are flexible enough to incorporate changes. Such flexibility in turn ought to be grounded on legal and administrative provisions that are responsive to the demands of indigenous organizations; otherwise, indigenous grassroots efforts will not lead to the transformation of social policies. As I show in this dissertation, INTs encounter serious difficulties in openly using and promoting an intercultural approach to health care because their intercultural training does not "fit" the model of care the government has in place. Despite the existence of MoH's regulations promoting the use of an intercultural approach, health services remain a monocultural endeavor.

In broader terms, scholars argue that there are two ways in which interculturalidad could be promoted; as either a state policy or a grassroots effort. Indigenous organizations and the State have different approaches to interculturalidad. According to Walsh (2008) for example, when indigenous organizations use interculturalidad, it expresses a need for the nation to recognize the importance of having all the different cultural groups represented in national projects. On the other hand, when the State uses the term interculturalidad, it refers to a technical approach that might acknowledge diversity but presents no further ambition to question or change the structural causes of hierarchical differences between cultural groups within a society (Walsh

2008). In this dissertation I show that despite the Peruvian State stating (through official documents issued by the MoH) the importance of the use of an intercultural approach in health care and even issuing guidelines about how to implement such an approach, nothing concrete happens at the level of health care provision. On the other hand, AIDESEPs bottom-up efforts at transforming health services through the recognition of the validity of indigenous medical systems (where INTs could be the bridge between the Western and the indigenous medical system) do not go beyond small changes given that it requires the health system to be more flexible to intercultural health approaches.

1.2 INTERCULTURALIDAD AND HEALTH CARE

Interculturalidad has been part of debates around the provision of health care since the 1990s in Latin America. In Peru, contemporary intercultural health efforts modeled earlier efforts made by international organizations to create collaborative relationships between Western medicine and indigenous medical systems. Despite the progress made in terms of expanding the concept of interculturalidad to promote the integration of different medical systems with horizontal dialogue and mutual learning, a top-down style remains in most intercultural health projects (Lacaze D. 2002; Ramírez Hita 2010).

In Peru, the MoH is officially committed to promoting interculturalidad in the services it renders and also in the skills of its personnel. However, such commitments do not seem to reach places like Atalaya where health professionals seem ignorant of indigenous people's traditional medicine and is even treated with disdain. Indigenous medical practices are disregarded or even

ridiculed by mestizo[2] health workers in most cases. The local newspaper's webpage "*Gaceta Ucayalina*" posted this news (Figure 1) which shows the dismissive attitude towards indigenous people and their local illness explanations. This news excerpt provides an example of the way the health sector portrays indigenous people and their medical beliefs in Atalaya:

> ***Atalaya, February 2012*** - A mother from the district of Tahuanía - Bolognesi arrived in Atalaya bringing her child with a severe case of chronic malnutrition. [Cases like this] have only been seen in photographs of African children.
>
> The little boy [child's name] 1 year and 11 months old was still alive when he was admitted at this hospital. Her mother [mother's name] 26, was told by the healer that her child had been "*cutipado*[3]" by a monkey. For several months, she gave him medicinal plants to fight the progressive emaciation. Seeing no improvement, a few days ago she took him to the Health Center at Bolognesi, where she was told to take him to Atalaya.
>
> This morning, she arrived at the Health Center in Atalaya, bringing her dying son to the hospital. After the doctor's assessment, the child was diagnosed with MULTIORGAN FAILURE AND CHRONIC MALNUTRITION. Despite health workers efforts to revive the small child, he died at 10: 45 am.
>
> Through the pregnant mother's statements, we could perceive the terrible way the parents neglected their children. They failed to bring him to the Health Center in Bolognesi and rather decided to take their son who was vomiting and had diarrhea, to a healer, who told them that the "Monkey had *cutipado*" him. After the failed attempt to cure him with medicinal plants, they finally brought him to Atalaya, to die.
>
> Meanwhile Dr. [doctor's name], Health Promotion Coordinator of the Red De Salud N° 03, call upon the authorities of the Tahuanía district to invest in the health sector, to support child nutrition programs to prevent future similar cases in our province[4] (Alarcón 2012).

Figure 1. Newspaper excerpt showing health workers' perceptions of indigenous medicine

[2] I use the term *mestizo* to refer to those people who are not indigenous.
[3] This is a term to refer to a cultural bound syndrome that is explained further in this introduction.
[4] Atalaya, 12 de Febrero del 2012.- Una madre llegó desde el distrito de Tahuanía – Bolognesi trayendo a su menor hijo con un grave caso de desnutrición crónica que sólo se observaba en fotografías de niños africanos.
El niñito [nombre] de 01 año y 11 meses llegó aún con vida a este nosocomio; su progenitora Sra. XXX de 26 años, cuenta que el curandero les dijo que el Mono le había "*cutipado*"; por varios meses le dieron vegetales para que recuperara del enflaquecimiento progresivo; al no ver mejoría lo llevó hace unos días al centro de salud de Bolognesi, donde le recomendaron el traslado a Atalaya.
Hoy por la mañana llegó al centro de salud de Atalaya, trayendo a su hijo agonizante al nosocomio, tras evaluación la doctora de turno diagnosticó: FALLA MULTIORGÁNICA Y DESNUTRICIÓN CRÓNICA, a pesar de los esfuerzos del personal de salud por reanimar con sueros al pequeño, este falleció a las 10: 45 a.m.
Por declaraciones de la madre gestante, pudimos percibir el tremendo descuido de los mismos, quienes no acudieron al centro de salud de Bolognesi, sino que llevaron a su hijo entre vómitos y diarreas a un curandero quién les dijo que el "Mono le había cutipado" y tras el intento fallido con vegetales de curarlo, finalmente lo trajeron agonizando a Atalaya para que fallezca.
Por su parte la doctora XXX, coordinadora de la Promoción de la Salud de la Red de Salud N° 03, invoca a las autoridades del distrito de Tahuanía, que inviertan en el sector salud, apoyando a los programas de nutrición infantil y no tengamos que ver un caso similar en nuestra provincia.

In the above news excerpt we observe that the (indigenous) mother's actions (taking her child to a healer) are presented as irresponsible and as a sign of "neglect" since she should have taken her child to the Health Center first. Health workers on the other hand are portrayed as the ones who cared ("despite the efforts of health workers") and the ones who were trying to right the wrong things that had happened to the child.

This newspaper excerpt shows that the health sector still shows contempt towards indigenous people. Indigenous healers are seen to represent a competing, deficient system, and the role that indigenous healers still play in addressing peoples' heath needs is ignored. Blaming indigenous healers or the use of indigenous medicine oftentimes hides the deficiencies of a health system that is not able to reach indigenous people, among other reasons due to cultural differences, but also due to the huge inequalities that affect indigenous people and that keeps them as a marginal group.

An intercultural approach attempts at changing discriminatory perceptions of indigenous medical practices and indigenous healers, in order to create the necessary conditions for both systems to work together, collaboratively. However, the intercultural approach to health care can also be used as a political strategy to obscure the social determinants of health that affect indigenous people. Thus, intercultural health approaches end up focusing on supporting indigenous organization's cultural claims and in doing so, ignoring the pressing material needs and social marginalization they experience.

Indigenous organizations such as AIDESEP, have focused on two components of intercultural health care provision: recovering indigenous medical systems (so that they can interact with the biomedical system) and training health workers to in both medical system. Both components are necessary to achieve respectful interaction between indigenous and non-

indigenous people in health care settings; but an intercultural approach requires more than an attitudinal change. An intercultural approach to health should also aim at a more comprehensive questioning of the exclusion, denial and subalternization of indigenous people's capacity to produce knowledge. The question is how the exclusion and denial should be challenged.

For AIDESEP – as we will see in this dissertation – intercultural health policies ought to look for the recognition of indigenous medical knowledge as equally important and equally valid as biomedical knowledge. But this recognition is certainly not enough. Intercultural health policies should also advocate improvements in indigenous peoples' health status and strengthen indigenous peoples' ethnic identity. As Escobar (1992) explains regarding social movements in Latin America, AIDESEP struggles with representation but also seeks to propose alternative ways of satisfying basic needs. AIDESEP, like other indigenous organizations in the region, advocates for changes in the way indigenous people have been treated historically. Intercultural health efforts (like any other intercultural effort) cannot ignore the historical asymmetries in which indigenous people have been located vis-à-vis non indigenous people. Through this case study, I show that even when changes are attained at the local level to transform governmental health services, the ongoing exclusion of indigenous people that result in their poor living conditions remain to be addressed. As long as indigenous people remain marginal to social and economic improvements, intercultural health will not transform the health status of indigenous people.

AIDESEP's effort to improve the health services that indigenous people receive in the Peruvian Amazon through training indigenous youth has two goals. On the one hand, AIDESEP wants to promote the recovery of indigenous medical traditions by educating indigenous youth in such knowledge. This will hopefully lead to continued development of indigenous medical

knowledge. On the other hand, AIDESEP wants to engage with the State to improve the services provided for indigenous people. However, AIDESEP's initiative overlooked that INTs alone could not "fight" against a health system that is built on a monocultural model of care.

AIDESEP has managed to make sure the INTs hold a degree that would allow them to work at a government health facility. The problem is that there are few opportunities to apply an intercultural approach in the health services provided within MoH's facilities.

As we will see in this dissertation, AIDESEP is advocating for services that respect indigenous peoples' worldviews in the health care arena. AIDESEP does not render Western medical knowledge as invalid. The intercultural health project AIDESEP envisions is one in which indigenous medical systems are rescued, supported and developed by the State. Furthermore, the project seeks to establish a relationship of collaboration with Western medicine. The question that I address is whether such project is feasible without strong political support from AIDESEP and long-term commitment from the MoH.

This dissertation is grounded in descriptions of INTs everyday activities in which sometimes they comply with standard biomedical procedures, and in other occasions, the INTs adapt services through the use of indigenous approaches, treatments and medical technologies. In this sense, my dissertation contributes to studies on medical pluralism that have shown that biomedicine's position is not always hegemonic. Biomedicine has its limitations when implemented in places where other medical systems are available (Singer, Davison et al. 1988). The intercultural approach to health care is grounded on biomedicine's need to collaborate with other medical systems.

At a theoretical level, it is possible to imagine that indigenous medical systems and Western medical systems work in a collaborative way and that both sides recognize the other as

equally effective and valid. However, as Ramirez Hita (2009) explains, for intercultural health projects to really occur those in charge of implementing them ought to recognize the validity of the theoretical arguments that sustain intercultural health: that indigenous medical systems are effective and scientific[5]. Without a transformation of the way indigenous medical systems are perceived by health professionals no significant changes will be achieved in intercultural health. INTs efforts show how challenging implementing intercultural health efforts are when other health professionals do not accept indigenous medicine as an alternative option.

1.3 INDIGENOUS HEALTH, INTERCULTURAL HEALTH CARE PROVISION AND THE CASE OF AIDESEP

The health of indigenous people in Peru, as in the rest of Latin America, is poor in comparison with the health of the non-indigenous population (Psacharopoulos and Patrinos 1993; Alderete 1999; Bird 2002; Hall and Patrinos 2005). One reason for this situation is that indigenous people rarely use the health services available for them (MINSA 2002; Sáez Salgado 2007). Several factors explain the limited use of governmental health services by indigenous people. The most mentioned factors are lack of trust between indigenous people and health workers and the lack of culturally-appropriate health services. Culturally-appropriate health services include (but are not limited to) having health workers who speak the local language (Mora and Villavicencio Rivera 2006; Morales Aldana 2006). Other factors include the lack of health workers committed to long-term placements in indigenous communities, and the

[5] Indigenous medical practices are also the product of years of trial and error. Healers have to practice and corroborate that specific medicinal plants, and rituals are effective to heal specific ailments.

geographic barriers to access a health facility (Mora and Villavicencio Rivera 2006; Morales Aldana 2006).

In order to remedy this situation in Peru, both the Peruvian MoH and AIDESEP have developed strategies geared towards introducing changes in health services to make them more culturally-appropriate for indigenous people. The MoH, for instance, has followed recommendations issued in 1993 by the Pan American Health Organization (PAHO) as a result of the "Summit on the Health of Indigenous People", that attempted to incorporate an intercultural approach to health care[6].

To this end, the MoH has issued several official documents, legal regulations and manuals promoting the importance of having an intercultural approach to health (MINSA 2002) [7]. These documents, and most importantly, the messages and guidelines oriented towards a more open relationship with indigenous medical practices, have failed to reach health workers in places like Atalaya. Despite serving an important number of indigenous people, health workers in Atalaya continue to base their services exclusively on a biomedical model of care.

The intercultural approach to health proposed by AIDESEP is one that aims at improving indigenous peoples' health by strengthening indigenous medical systems and through complementary work with modern Western medicine, so both indigenous and Western worldviews should be part of the health care system (Reategui Silva 2003). For AIDESEP's Indigenous Health Program (Programa de Salud Indígena – PSI), the strengthening of indigenous medical systems is deeply tied to the revitalization of indigenous societies through the

[6] For the MoH, an intercultural approach to health is one that "recognizes the need to develop solidarity and respect as well as competencies and abilities (among health providers) that enables them to recognize the cultural, social, economic and linguistic differences that exist in their relationship with the "other' [i,e. indigenous people]." (MINSA 2004)

[7] These documents will be expanded in Chapter 3

reaffirmation of their ethnic identity (Reategui Silva 2008). The PSI is based on the idea that the monocultural model of health care provided in governmental health facilities has affected indigenous people's own perceptions of their medical traditions. This is the product of the historical marginalization of indigenous culture and practices and oftentimes results in the abandonment of indigenous practices (Reategui 2008). By advocating official recognition of indigenous medical practices as important and instrumental to improving the health status of indigenous people, AIDESEP attempts to change the way non-indigenous people in the health sector value indigenous medical practices and making indigenous people themselves value their own medical traditions.

Although AIDESEP's PSI promotes a number of different strategies, this dissertation focuses on the AIDESEP project to develop effective training and education programs for Intercultural Nurse Technicians (INTs). INTs follow the same curricula as any Nurse Technician in Peru (a three year degree). Such national curricula is complemented with an equivalent number of credits and hours studying indigenous medical practices[8]. These INTs are now working – as other nurse technicians – at governmental health facilities. INTs are expected to use their training in both indigenous and Western medicine to improve the quality of services provided to indigenous communities using an intercultural approach.

This dissertation analyzes the everyday intercultural strategies INTs use in the context of health care provision at governmental health facilities in the Peruvian Amazon. It shows the structural and practical challenges to using both indigenous and biomedical approaches to health. My dissertation also presents the way the hierarchical structure of the health system prevents

[8] A more detailed description of the educational program is provided in Chapter 2, section 2.3.

INTs from actively promoting changes to health services that can better accommodate the cultural differences of indigenous patients and respond to their health needs.

Through a detailed examination of an intercultural health effort promoted by an indigenous organization, this dissertation shows that indigenous organizations have difficulty implementing a genuine intercultural approach. It is difficult to make inroads and effective structural changes because of the unequalpower dynamics in health service provision. Structural and relational inequalities between indigenous people and health workers and between indigenous medical systems and Western ones are at the basis of the limited impact INTs intercultural health efforts are achieving beyond the communities they work in.

INTs efforts provide the context for arguing that there are two discursive frameworks that are central to intercultural health (and interculturalidad for that matter). Interculturalidad requires both strong political support (from indigenous organizations) and/or legal and administrative frameworks (from the State) in order for them to make the long lasting changes in health service provision and health policies for indigenous people.

1.4 PREPARING FOR THE FIELD

Fieldwork was conducted in the Province of Atalaya in the Peruvian Amazon. Before leaving for Atalaya I needed AIDESEP's institutional support given that I was planning on visiting several indigenous communities affiliated with AIDESEP. I was able to obtain their support due to my existing relationship with people within the institution but, specifically, with people in the PSI. My relationship with AIDESEP began in 2003 when I worked for a year as an advisor for the *Programa de Mujer Indígena* (Indigenous Woman's Program).

The Indigenous Woman's Program shared an office with the PSI. It was there where I met Juan Reátegui, who belongs to the Awaruna indigenous group and has an undergraduate degree in nursing. He was the Director of the PSI at the time – as will be discussed in Chapter 2 – the one who set the basis of AIDESEP's intercultural health approach. It was through him that I first heard about the PSI's project in Atalaya. The program aims to educate indigenous youth as intercultural nurse technicians. In 2007, when I started my doctoral studies at the University of Pittsburgh, I told Juan about my interest in doing my research on intercultural health.

In the summer of 2008, when I travelled to conduct pre-dissertation fieldwork, I interviewed Juan Reátegui and Dr. Alfredo Rodriguez, his technical advisor and the main promoter of the INTs program. He put me in touch with Cynthia Cárdenas, an educator who had worked for the project in Atalaya and who travelled with me to introduce me to the INTs for the first time.

In 2009, I requested Juan Reátegui write me an institutional letter of support. The letter of support helped me apply for funding. In 2010 when I was ready to begin my fieldwork, Juan had moved to Ecuador and he was no longer the Director of the PSI. Nevertheless, other people at the PSI who were acquainted with my work were supportive of my research. The staff were interested in learning about how the INTs faired in their employment and whether the program was successful or if the INTs were encountering any difficulties. I agreed to share the results of my research with them and I received a letter from AIDESEP, which introduced me to indigenous organizations in Atalaya and explained that I was contributing with the PSI.

When I arrived in Lima in September of 2010, it was not possible to get adequate information on the number of INTs currently working or their exact location. I left for Atalaya in mid-September. My first stop was in Pucallpa, the capital city of the Department of Ucayali. In

Pucallpa I contacted the regional indigenous organization (ORAU – Organización Regional de AIDESEP Ucayali) and informed them of my research and made attempts to meet with health authorities. However, I was only able to meet with the person in charge of the local division of the National Strategy for Indigenous People (*Estrategia Nacional Para Pueblos Indígenas)* who provided me with some information of two INTs working in the Province of Coronel Portillo, near Pucallpa. They were not going to be part of my research since I had defined my area of study as only the Province of Atalaya.

I arrived in Atalaya at the end of September. My first task was to get a complete list of the INTs working in the Province of Atalaya. Once I had the list, I needed to inform the INTs I was going to visit them. I also needed to figure out the logistics of how to reach the INTs since most of them were working in quite isolated communities. I was lucky that the National Municipal Elections were scheduled for October 3rd, 2010. Since voting is compulsory in Peru, some of the INTs would have to travel to Atalaya to vote. I was able to organize a meeting with them, and since I had met them in 2008 they still remembered me. With their help, and their knowledge of the geography of the region, I was able to plan my fieldwork. All the INTs told me I could stay with them or at health post and thus lodging was not a problem. Armed with all this information, I left for the first community in the district of Sepahua at the beginning of October 2010, right after the elections were over.

1.5 METHODS

Fieldwork lasted twelve months. It began in September 2010 and ended in September 2011. I spent my first month in Lima and Pucallpa, securing authorization and support from both

AIDESEP and the MoH. Throughout the following ten months, I visited every INT working in a health facility in Atalaya at the time of my fieldwork[9]. In total, I visited six INTs working in five sites in the province of Atalaya. Two INTs worked together at one health facility. Three of the field sites were indigenous communities and two of the field sites were towns where the health facility served both indigenous people and *mestizos.*

Three INTs were working at Health Posts where they were the only health personnel. The other three INTs I visited were working at Health Centers where they shared responsibilities with as many as ten other health professionals. I use the term health workers to refer to any health professional with a post-secondary degree who works at a governmental health facility. The most common professions held by health workers were nurse technicians, registered nurses, midwives, medical doctors and dentists.

A number of the INTs were working among their own ethnic group and sometimes even in their own communities. Others had a more challenging scenario working among other ethnic Amazonian groups whose language they did not understand.

Fieldwork focused on the work of the INTs at health facilities and in their use of an intercultural approach understood primarily as the use of both indigenous and Western medicine together. The two core data collection methods were interviews and participant observation.

[9] Out of the 20 INTs who completed the degree, 6 were working in Atalaya, 1 in the Province of Coronel Portillo and 1 in the Province of Purús. One was on maternity leave, 2 were working for mining companies and the other 9 did not hold a job in the health sector but either were stay-home mothers, held a health-related job with mining companies or were running for office.

1.5.1 INTERVIEWS

I collected information about indigenous peoples' ideas and perceptions of intercultural health provision (and their expectations of governmental health services) through semi-structured interviews with health workers (see Appendix C) and INTs (see Appendix D), and through informal conversations with people in the communities which I recorded in my field notes given that people were uncomfortable with the digital recorder (see Appendix A for questionnaire).

I interviewed an average of ten people in each fieldsite. In the interviews community members talked about their satisfaction with health services provided by the INTs and their experiences with health services (whether in their community or in another town), the local indigenous medical practices and their use of indigenous medicine and Western medicine. In each site, I developed a closer relationship with at least four women with whom I had ongoing conversations about the aforementioned topics.

Table 1. Types of informants and number of people interviewed per field site

Type of informant	Data Collection	Number of people I interviewed/structured conversations per field site					TOTAL
		Shari	Nariteri	Shipaya	Bolognesi	Oventeni	
Women who use health services	Field notes	6	4	5	5	6	**30**
Community Leaders	Digital Audio	1	1	2	0	2	**6**
Indigenous Healer	Field notes	2	1	0	0	2	**5**
Health Worker	Digital Audio	0	0	0	6	4	**10**
INT	Digital Audio	1	1	1	1	2	**6**
TOTAL		**10**	**7**	**8**	**12**	**16**	**57**

While in the city of Atalaya I interviewed two INTs that were not working in the Atalaya province during the period I was conducting my fieldwork, but who had previous experience working at a government health facility in Atalaya. I held a two-hour interview with each of them and this information was analyzed together with the interviews of the six INTs I did visit in their field sites.

In all of the five field sites, I interviewed each INT at least two times. I also conducted ten semi-structured interviews with *mestizo*[10] health workers providing services in the same health facilities where INTs were working. And then an additional five interviews with health workers form the same district that I met in the public boat transportation services. This allowed me to understand their experiences providing health care for indigenous people and their understanding of intercultural health.

All these interviews were recorded and then transcribed and coded (see section 1.5.3 for further description).

1.5.2 PARTICIPANT OBSERVATION

Interviews were complemented by participant observation in and outside of health facilities. At health facilities I observed the interactions of various groups (for example the interactions between the INTs and other health workers, between INTs and their patients, and between indigenous healers in the few occasions – twice throughout my field work). I sat during the hours of operation (8 a.m. – 1 p.m.) in the waiting area of the health facility, from Monday through Saturday, and asked about the reason for their visit to the health facility. With those with

[10] These interviews are not part of this dissertation since I am focusing on the experiences of INTs. In some specific cases I use the testimonies of mestizo health workers recorded in my fieldnotes.

whom I developed a closer rapport I asked questions about the INTs, their use of indigenous medicine and their strategies when a family member fell ill.

My main informants were women with small children who went to the health facility for vaccinations and child development monthly evaluations, and pregnant women who came for their pre natal appointment. Since they were the ones in the community who had a closer relationship with the INT, I considered their opinions provide a better understanding of the way the INT operated within the health facilities, specifically if he was –or not– using an intercultural approach.

Conversations were usually in groups but there will always be one or two women who were more vocal and who would take the lead in answering my questions. In that way the perceptions I collected are from those women who visited health facilities and not from those who did not use them.

In those field sites where the health facility was a Health Post (three of the five field sites), my lodging was one of the rooms of the Health Post; as a result I learned about early morning and late night emergencies when people came to knock at the door asking the INT to see a patient. Sometimes they would even ask for my medical advice thinking I was a nurse.

I also conducted participant observation outside the health facilities, mostly in the afternoons after the Health Post and Health Center were closed. I participated in birthday parties and afternoon soccer games where I sat with women to watch the men play. Every day before sunset, I went to the river with other women to bathe, and during that time, we had conversations about various topics. If we happened to discuss something about health care (an accident somebody experienced in the past, birth practices, childhood illnesses, etc.) I started to ask more questions to clarify the information and understand the decisions around the use of indigenous

and Western medical care. Afterwards I went back to my room and wrote down the information in my notebook.

During social events such as birthday parties, I had the opportunity of engaging and recording conversations with local leaders and local people. I used this opportunity to ask about the INTs work and the local use of indigenous medicine. In each field site I conducted at least one interview with a community leader (except in Bolognesi where the mayor was away during the month I was there) and in three of the five fieldsites I was able to interview an indigenous healer (See Appendix B for interview questionnaire for Indigenous Healer).

Participant observation of indigenous healing also occurred when I was told about someone who was sick and was receiving the treatment of an indigenous healer. This happened four times throughout my fieldwork:

- Fifteen year old with eye ache
- Twelve year old who had been hit by a falling palm tree
- Woman in labor
- Young man who had been the victim of witchcraft

In such occasions, I went to the patient's home (or outside the house where the treatment was being provided). It was a "public" venue because other people would come and sit around the healer. Conversations would occur about the ailment and usually the family would explain to me the ailment and the treatment that was being offered. It was also an opportunity for other people to share stories about similar situations in the past, and the role that indigenous healers had played in the recovery of the patient. Story telling was a common practice after sunset and I played special attention to those stories that had to do with illnesses. I recorded at least three such stories per field site, some were more elaborate than others and allowed me to understand

the various explanations indigenous people had for illnesses as well as the difficulties of accessing specialized health care when necessary, oftentimes when accidents occurred with machetes and arrows.

My research aimed at documenting the lived experiences of the INTs and the strategies they employed as they provided healthcare services to indigenous communities. While in the field, I specifically looked for examples when INTs (a) used an intercultural approach, (b) shared or reported their intercultural efforts, and (c) advocated for a more comprehensive understanding of the value of indigenous medicine and indigenous healers. Before going to the field, I had broadly defined the use of an intercultural approach as the use of both indigenous and Western medicine to provide care, working side by side with indigenous healers. However, as I collected data it became evident that this definition did not capture the diversity of intercultural health practices INTs used. I began to noting any time when INTs did not use biomedicine by itself. The examples I collected were both observed or narrated by the INT or another informant.

I spent around six weeks in each site, conducting an ethnography of health service provision (as opposed to an ethnography of the communities where services were provided). In each field site I took extensive field notes about the everyday activities at the health facility. While in the communities, I learned how the national insurance plan functions. I also learned how the nutritional program works and helped arrange medications in the pharmacy or counted the bags of rice, beans and *papilla* (baby's food) that arrived for distribution as a part of such national plans.

As part of my activities in each community I would also visit families in the community who invited me to their homes to have some *masato*[11]. In each community, an average of three

[11] Traditional beverage made out of fermented mandioca (yuca) and sweet potato (camote).

people would invite me to their homes on a regular basis. I used those opportunities to have conversations about people's perceptions of health services and the efforts of the INTs to use both sets of medicine at the health facility. The wives of INTs proved to be excellent informants; they also played an important role in introducing me to other women in the community. I developed a closer relationship and was able to have more nuanced conversations about health care with an average of four women in each visited community.

I had the opportunity to travel with some of the health workers to other communities they served. The communities were located two or three hours away from the health facility. Sometimes we travelled by boat and sometimes by foot, taking vaccinations or medications for a particular patient. In one case, I accompanied the health worker in the referral of three pregnant women to a health facility seven hours away by boat where there was a doctor and an ultrasound machine. Since my goal was to have a nuanced understanding of health service delivery at health facilities and the challenges and opportunities health workers faced to deliver intercultural health, I tried to participate in every activity they undertook (See Table 2).

Table 2. Types of activities related to health care I participated in each field site

Type of activity	Field sites where I participated in such activities				
	Shari	Nariteri	Shipaya	Bolognesi	Oventeni
Visiting distant communities by foot or boat to vaccinate children		x	x		
Doing home visits to woman in advanced stages of pregnancy.		x			x
Transporting a sick person to another town where there were medical personnel able to address his/her health problem.	x		x		
Doing home visits to individuals who were too sick to go to the health facility.		x		x	
Travelling to other communities to pick up medications from other health facilities.	x				x
Helping women in labor at home and/or the health facility		x	x		x
Travelling to another health facility to store the vaccines since the INT's Health Post's refrigerator ran out of gas.	x		x		
Distributing food supplies sent by the government.	x			x	x

The descriptions of these activities were noted in my notebook at the end of the day. Participating in all these activities allowed me to ask questions that enabled me to better understand the use of an intercultural approach. Overall, I learned it is a challenge to implement even the simplest medical protocol in a facility without electricity and medications.

Although my original plan was to stay in Atalaya for ten consecutive months, I had to travel back to Lima on three occasions. The first time was to attend a conference in Guatemala organized by the Inter-American Foundation, the agency that funded my fieldwork. The other two times I traveled to Lima to vote in the presidential elections. Since voting is compulsory in Peru, INTs had to leave their workplace to go to the nearest city to vote to avoid a fine. They told me they usually stayed in the nearest towns for more than a week getting medications and buying food supplies for themselves.

Returning to Lima gave me the opportunity to start transcribing some of my notes into a computer. Only two of the sites I visited had electricity and, since most transportation was done by river, I decided against bringing my laptop along. While in Lima I shared some of my results with members of AIDESEP's PSI and was able to learn more about the INT training program.

1.5.3 PRE DISSERTATION FIELD WORK

In 2008 I conducted two months of pre-dissertation fieldwork in Lima, Pucallpa and Atalaya. In Lima, during this pre-dissertation fieldwork, I gathered background information about AIDESEP's PSI by conducting interviews and reviewing institutional documents such as project descriptions and brochures. I also travelled to Pucallpa to interview indigenous leaders and people from NGOs implementing intercultural health projects, such as Salud Sin Límites in Ayacucho. In Atalaya, I met INTs for the first time and had the opportunity to conduct semi-

structured interviews with the twelve INTs regarding their initial experiences working at governmental health facilities (see Appendix E). I also asked them about their expectations using an intercultural approach to health care. In addition, I interviewed health workers from three different health facilities where INTs had been working, as well as people who had been involved in the INT training project, including an indigenous healer and three health authorities. All these interviews are also part of the current dissertation.

Table 3. Names and positions of informants who represented the MoH or AIDESEP

	Name	Position	Institution	2008	2010-2011
1	Dr. Neptali Cueva	Director	Center for Intercultural Health	x	
2	Dr. Oswaldo Salaverry	Director	Center for Intercultural Health		x
3	Dr. Adelmo Guerrero	Director	Red de Salud Atalaya (MoH)	x	
4	Dr. Luis Adauto	Director	Microrred de Salud de Sepahua		x
5	Dr. Juan José Pagan	Director	Red de Salud Atalaya		x
6	Lic. Juan Reategui	Director Indigenous Health Program	AIDESEP	x	
7	Lic. Isolina Valdes	Program Coordinator – Programa de Formación de Técnicos en Salud Intercultural	AIDESEP	x	x
8	Lic. Cynthia Cardenas	Academic Advisor – Programa de Formacion de Técnicos en Salud Intercultural	AIDESEP	x	x
9	Dr. Alfredo Rodriguez	Academic Advisor – Indigenous Health Program of AIDESEP	AIDESEP	x	
10	Lic. Esdras Silva	Responsible of Indigenous Helath – Ucayali Indigenous Organization (ORAU)	AIDESEP	x	
11	Daysi Zapata	President Ucayali Regional Indigenous Organization (ORAU)	AIDESEP	x	
12	Dr. Rosa Malca	Executive Director	Salud Sin Limites	x	

While in the city of Atalaya in 2010 and 2011, I also conducted in-depth interviews with health authorities, mostly about the local efforts to incorporate an intercultural approach in the services they provide and the role that INTs could play in such efforts.

1.5.4 INTERVIEW AND FIELDNOTES ANALYSIS

All interviews were recorded using a digital recorder and the MP3 files were downloaded into my personal computer. I transcribed all my field notes and all the interviews with INTs and transferred them to Atlas-ti version 5.7.1, a qualitative data analysis software. I used the software to codify both interviews and field notes.

I codified the information as I read it, and analyzed both data collected in 2010 - 2011 and in 2008. I used in total 28 codes grouped in 12 family codes (see Table 4). I used the codes to codify my field notes, the transcription of the documentary of AIDESEP's Indigenous Health Program, the interviews conducted in 2010-2011 and the ones conducted in 2008. After the first round of codification I had over 50 codes which I later grouped and/or refined into the final 12 family codes.

Table 4. Family codes and codes used to analyze data

Family Codes	Codes
1. Health Facilities	1.1. Organization
	1.2. Supply problems - medications - energy - health workers
	1.3. Duties at Health Center
	1.4. Duties at Health Post
2. Advocacy of indigenous medicine	
3. Communities use of western medicine	
4. Communities use of indigenous medicine	
5. Communities perception of INT	
6. Definition Intercultural Health	6.1. By INT
	6.2. By Health Worker
7. Discrimination against INTs	7.1. By other Health Workers
	7.2. By patients
8. Intercultural Health	8.1. Use of Indigenous Medicine by INT
	8.2 Referral between medical systems
	8.3 Working together with Indigenous Healer
	8.4. Obstacles to intercultural health
9. Illness episode	9.1. Solved by indigenous medicine
	9.2. Solved by Western medicine

10. Indigenous Health practices	10.1 Explanations of disease
	10.2 Indigenous worldview
	10.3 Local cultural practices related to health
	10.4. Medical Pluralism in health decisions
11. INT work	11.1. Advocacy for indigenous medicine
	11.2. Suggestion to use indigenous medicine
	11.3 Adapting to communities they serve
	11.4 Use of western medicine
12. Relationships developed by INT	12.1. With community members
	12.2. With indigenous healers
	12.3. With other health workers: Good / Bad
	12.4. Health Promoter

1.5.5 DOCUMENT ANALYSIS

In order to write the history of the Indigenous Health Program of AIDESEP (Chapter 2) I collected institutional documents and other publications in which the history of AIDESEP and of the Indigenous Health Program have been documented. Some of the documents were available online and I could download them, while others (such as internal reports) were shared with me by friends working in AIDESEP.

Table 5. Types of documents analyzed to write about AIDESEP and AIDESEP's Indigenous Health Program (*Programa de Salud Indígena*)

Document Title	Type of Document	Institution	Year	Themes
Por qué y cómo se construye AIDESEP - La Historia de la Organización Indígena. AIDESEP. Lima, Publicaciones AIDESEP	Institutional Brochure	AIDESEP	No date	AIDESEP's history
AIDESEP y la Perspectiva Indígena	Book excerpt	Fundación Karen Elise Jensens y NORDECO	2003	▪ AIDESEP's history ▪ AIDESEP's position about indigenous health
El Programa de Salud Indígena - PSI-AIDESEP	Interview to Juan Reategui	Fundación Karen Elise Jensens y NORDECO	2003	▪ History of PSI ▪ PSI lines of work
Las Políticas de Salud de los Pueblos Indigenas de la Amazonia Peruana	Book written by former Director of the PSI	Reategui, J. AIDESEP.	2005	AIDESEP's position about indigenous health
Programa de Salud Indigena	Excerpt of AIDESEP's web page	AIDESEP	2007	▪ Goals of the PSI ▪ History of PSI ▪ PSI lines of work

Proyecto Piloto de Formación de Técnicos en Salud Intercultural Amazónica de Atalaya. Informe Final - Segunda Fase.	Final project report	Fundación KAREN ELISSEN YENSEN - NORDECO/ AIDESEP.	2008	▪ Project Objectives ▪ Courses Taught ▪ Definitions of intercultural health
Formación de Enfermeros Técnicos en Salud Intercultural: Una experiencia de cooperación entre las organizaciones indígenas de la Amazonía Peruana, el Estado y un Instituto Tecnológico	Academic Article	UNESCO	2009	▪ Project Objectives ▪ Courses Taught ▪ Definitions of intercultural health
De Médicos y Sheripiaris: Proyecto Piloto de Salud Intercultural.	Transcription of Documentary	Fundación KAREN ELISSEN YENSEN - NORDECO/ AIDESEP.	2010	▪ Project Objectives ▪ Definitions of intercultural health
XII - Congreso Nacional. Informe - Balance de Gestión del Consejo Directivo Nacional	Institutional Report of activities done between 2009 and 2011	AIDESEP	2011	▪ Project Objectives ▪ AIDESEP's position about indigenous health
Perú: Veinte jóvenes indígenas se gradúan de enfermeros en salud intercultural	Press Release	AIDESEP	2008	Project Objectives

These documents provided me with background information to write Chapter 2 and portray the history of the organization and the context in which it was created. The information I was able to obtain from each document was organized along the following themes and sub themes:

Table 6. Themes and sub themes defined to analyze AIDESEP-related documents

THEME	Sub themes
AIDESEP	AIDESEP's history
	AIDESEP's position about indigenous health
AIDESEP's Indigenous Health Program	History of AIDESEP's Indigenous Health Program: When and why it was created.
	AIDESEP's Indigenous Health Program: Goals and lines of work
The Intercultural Nurse Technician's project	The Intercultural Nurse Technician's Project Objectives

	Courses Taught to Intercultural Nurse Technicians
Intercultural Health for AIDESEP	Definitions of (or ideas about) intercultural health

I read each document in detail and identified and transcribed those excerpts that I deemed useful. I later translated them and organized them in a chronological order.

Some of these documents contained interviews of people I also interviewed for my research, such as Juan Reátegui, so I was able to provide more insightful representation of their ideas and the way their ideas changed over the years. I also used excerpts from a documentary filmed in 2006 that narrates AIDESEP's intercultural health project in Atalaya. The documentary is called "Medicos y Sheirpiaris: Un proyecto de Salud Intercultural en la Amazonía Peruana." It was released in 2008 and it contains interviews of students, indigenous leaders, health authorities and the project director. I transcribed the interviews and used excerpts from them to more accurately represent the project goals.

These documents enabled me to narrate the upsurge of AIDESEP and its indigenous health program and thus provide a historical context to the Intercultural Nurse Technician's project. The analysis of these documents allowed me to explain that the INT's project was a result of several years of experience trying to improve indigenous health.

In order to write Chapter 4 about the MoH's stance on intercultural health I analyzed documents from both the Pan American Health Organization (PAHO) and the MoH regarding this issue. The following table presents the documents and types of documents used to write about the MoH's official position on intercultural health:

Table 7. Types of documents analyzed to write about the Ministry of Health's official position on Intercultural Health (Ministerio de Salud – MINSA)

Document Title	Type of Document	Institution	Year	Themes
Modelo de Abordaje de Promoción de la Salud	Technical Document	MINSA	2004	▪ Intercultural Health and Human resources
Constitución de la Unidad Técnico Funcional de Equidad de Género, Derechos Humanos e Interculturalidad	Resolucion Ministerial – Legal resolution from the MoH	MINSA	2005	▪ Definition of interculturalidad ▪ Guidelines to implement an intercultural approach to health
Marco conceptual de los derechos humanos, equidad de género e interculturalidad en salud	Technical Document	MINSA	2005	▪ Definition of interculturalidad ▪ Guidelines to implement an intercultural approach to health
Norma Técnica para la Atención del Parto Vertical con Adecuación Intercultural	Technical Document	MINSA	2005	▪ Definition of interculturalidad ▪ Guidelines to implement an intercultural approach to health
Norma Técnica para la transversalización de los enfoques: Derechos Humanos, Equidad de Género e Interculturalidad en Salud	Technical Document	MINSA	2006	▪ Definition of interculturalidad ▪ Guidelines to implement an intercultural approach to health ▪ Intercultural Health and Human resources
Acerca del CENSI	Excerpt from MoH's Web page	MINSA	2009	▪ Description of the National Centre for Intercultural Health
Guía para el Personal de salud sobre: Dialogo intercultural en Salud - DICS	Unpublished document	MINSA	2010	▪ Intercultural Health and Human resources

In order to identify the information I wanted regarding the MoH's definition and guidelines about intercultural health (themes listed in the last column of Table 7), I skimmed through them, identifying the excerpts that described the MoH position on intercultural health and the guidelines to implement such approach: training human resources, interaction between medical systems and/or promotion of community participation to learn about their demands on health care. Furthermore, I was interested in analyzing the rationale for using an intercultural approach. The analysis of these documents allowed me to have a clearer understanding of the

MoH position, contrast it with what mestizo health workers in the places I visited said about intercultural health, and also compare it with AIDESEP's position.

My understanding of the MoH's position of intercultural health demanded me to review documents by the WHO and PAHO on intercultural health, indigenous medicine and primary health care since they provided the logical framework for the interventions in Peru on indigenous health. The documents were reviewed trying to create a timeline of the way in which current ideas about intercultural health originated in the efforts from 1970s on Primary Health Care which stressed the importance of incorporating indigenous healers in national health systems. The following table shows the documents and themes analyzed to this end.

Table 8. Types of documents analyzed to write about the development of the concept of intercultural health in the Pan American Health Organization

Document Title	Type of Document	Institution	Year	Themes
International Conference on Primary Health Care, Alma-Ata	Conference Proceedings	WHO	1978	▪ Primary Health Care/ ▪ Participation of Traditional Healers in national Health systems
The Promotion and Development of Traditional Medicine.	Technical Document	WHO	1978	▪ Participation of Traditional Healers in national Health systems
The Health of Indigenous Peoples of the Americas.	Resolution	PAHO	1993	▪ Demands of indigenous peope for culturally-appropriate health services
Incorporación del enfoque intercultural de la salud en la formación y desarrollo de recursos humanos.	Technical Document	PAHO	1998	▪ Combining Indigenous and Western Medical systems ▪ Definition of Interculrural Health ▪ Role of Human resources in Intercultural Health
Harmonization of Indigenous and Conventional Health System in the Americas. Strategies for Incoporating Indigenous Perspectives, Medicines, and Therapies into Primary Health Care.	Technical Document	PAHO	2002	▪ Combining Indigenous and Western Medical systems

Health of indigenous people: a challenge for public health.	Report	PAHO	2002	▪ Demands of indigenous peope for culturally-appropriate health services
Una visión de salud intercultural para los pueblos indígenas de las Américas	Technical Document	PAHO	2008	▪ Definition of Interculrural Health ▪ Demands of indigenous peope for culturally-appropriate health services

I attempted to see the "evolution" of the ideas behind intercultural health: interaction between medical systems, critical stance vis-à-vis biomedical hegemony, importance of community participation and the role of indigenous organizations. This review also enabled me to make chronological connections between the development of discourses about intercultural health and the development of social processes such as the increased mobilization and political participation of indigenous people in Latin American countries.

Once I completed fieldwork I learned about the regional news website called "Gaceta Ucayalina" that has a webpage on news from Atalaya and a special section with official news provided by the local health authorities regarding various issues around health care such as the building of new health posts, immunization campaigns, successful surgeries and other related topics. I browsed through the news published between September 2010 and September 2012 searching for information that I could use to better represent the communities and towns where I did my fieldwork. However, the only information I ended up using was the excerpt presented in Figure 1 that represents quite accurately the "official" position and prejudices of most health workers regarding indigenous medicine.

I gathered statistical information from local health offices regarding the number of health workers per health facility, the size of the population they served and the number of indigenous communities in the jurisdiction of each visited health facility.

1.5.6 IRB approval, translation and methodological limitations

The research presented in this dissertation was approved by the Institutional Review Board of the University of Pittsburgh. All the names of informants –except of those with an official position within AIDESEP or the government – are pseudonyms in order to safeguard the identity and privacy of the informants who shared their views, stories and everyday lives with me.

I did all the translations from Spanish sources that appear in this dissertation. I also translated all research material, interviews and field notes which were collected in Spanish. One of the main limitations of this study is my lack of knowledge of the four different indigenous languages I heard over the course of my fieldwork. I had to rely on bilingual members of the community to act as interpreters during conversations.

This research has some limitations regarding the representativity of the informants' accounts. Luborsky and Rubenstein (1995) state that qualitative researchers ask, "What are the component of the system or universe that must be included to provide a valid representation of it?" (pg. 92). Following this rationale, and given that the focus of my research was health care provision by INTs, I choose to interview 6 types of informants:

(1) INTs

(2) People who use health services where INTs work

(3) Indigenous Healers

(4) Health workers who work with INTs

(5) Community leaders (authorities) of the communities where INTs worked

Such informants provided me with details of INTs work at the health facility; however, they mostly did so through an interpreter from the community and this could explain why I did not

collect much data that criticized INTs work. Another explanation for the lack of data that expressed a critical perspective on INTs work is that in two of the six field sites INTs were the first permanent health worker to ever be assigned to the community, and people were so content with such situation that did not find flaws in the INT's work.

1.6 DISSERTATION OUTLINE

The dissertation has four more chapters in addition to this introduction. Chapter 2 describes AIDESEP, the indigenous organization that promoted the educational project to train indigenous youth as INTs. In that chapter, I provide a historical description of the creation of AIDESEP. I describe the consolidation of this organization within the context of the development of indigenous social movements in Latin America. Chapter 2 also explains the nature of AIDESEP's *Programa de Salud Indígena* (PSI) and presents the strategies the organization uses to improve indigenous people's health and promote an intercultural approach to health care. The main sources for Chapter 2 are official AIDESEP documents (see Table 5) and the book about the PSI "Sueños Amazónicos: Un Programa de Salud Indígena en la Selva Peruana" edited by Soren Hvalkof[12] and contains interviews with several people (indigenous leaders, consultants, and other actors involved in AIDESEP's Indigenous Health Program), publications, as well as interviews carried out with Juan Reátegui, the first director of the PSI and the person first responsible for establishing the ideological trajectory of the PSI.

[12] Hvalkof, S., Ed. (2003). Sueños Amazonicos: Un Programa de Salud Indígena en la Selva Peruana. Copenhagen, NORDECO.

In Chapter 3, I present the Peruvian State's official position towards intercultural health. To that end, I analyze official documents and regulations (See Table 8) to illustrate the institutional approaches to indigenous health and intercultural health. Both AIDESEP's and the MoH's proposed strategies to intercultural health are a counterpoint to the concrete actions of the INTs who provide health care for indigenous people in Atalaya.

Chapter 4 presents the results of my fieldwork in the five field sites described in the previous section. In this chapter, I provide detailed ethnographic examples of the efforts of INTs to provide health services combining Western medicine and indigenous medicine (as well as other characteristics of intercultural health services). The information is presented in two broad sections, one that looks at those INTs working at a Health Post and those working at a Health Center. This distinction enables me to identify later in the chapter the conditions that facilitate or limit the use of an intercultural approach. I end the chapter with a discussion of the results, taking into account other studies that provide insights about the factors that come into play when projects such as the one promoted by AIDESEP are implemented. My focus is to rethink the challenges that confine INTs strategies and impede such efforts or projects from having an impact at the level of public policies, and sustainable.

In Chapter 5, I summarize the evidence presented throughout the dissertation. I discuss the differences between the use of interculturalidad by indigenous organizations and the use of interculturalidad by the State. I analyze the nuances that such a complex concept has in a concrete case such as the provision of intercultural health care in the Province of Atalaya. I argue that despite INT's resourceful ways of providing health services using an intercultural approach, no structural transformations are taking place (and AIDESEP would like to see structural change). There is also no region-wide improvement in services for indigenous people (a change

the MoH aspires to). INTs efforts remain under the radar despite AIDESEPs intended goals and the MoH official pro-intercultural health position geared towards the improvement of health services for indigenous people.

1.7 STUDY AREA

In this section, I present an overview of the social, historical and geographical context of the area where I carried out my fieldwork. The first section (1.6.1) provides a description of the broad regional context of Ucayali and the Peruvian Amazon. The second section (1.6.2) describes the indigenous population of the region, focusing on the three ethnic groups I worked with during my research (the Shipibo-Conibo, the Nahuas, and the Asháninkas/Ashéninkas); and the third and final section (1.6.3) provides an overview of the five field sites, highlighting the type of primary health care services people living in indigenous communities have access to.

1.7.1 REGIONAL OVERVIEW

Peru is divided into political and administrative units called *Regiones* (regions). A *Región* is subdivided into *Provincias* (provinces) and *Distritos* (districts). Research was conducted in the Atalaya province located in the Ucayali region. Ucayali, together with Loreto and Madre de Dios, are the three Amazonian regions of Peru. Atalaya is one of the four provinces of Ucayali (See Figure 1) and is located near the junction where the Tambo and Urubamba rivers join to form the Ucayali River. The Ucayali River continues north (becoming larger as more tributaries join it) until it reaches the town of Nauta in the Loreto region, where it joins with the Marañón

river to form the Amazon River. Both the Ucayali and the Marañón are two important tributary rivers of the Amazon from the Peruvian Amazon.

1.7.1.1 HISTORY OF THE STUDY AREA

The Ucayali region was "discovered" in 1557 by an expedition led by Juan Salinas de Loyola during his search for the mythical *El Dorado* and new territories for the Spanish crown (Hvalkof 2003). In descriptions of his expeditions, he noted that three indigenous groups - the Cocama, the Conibo and the Yine - controlled different sections of the Ucayali river. Missionary expeditions into the area began in the 17th century led by the Jesuits whose main base was in Quito (Ecuador) and the Franciscans whose base was in Lima. It took the missionaries more than seventy years to establish permanent missions in the region due to the constant attacks by indigenous groups who objected to or resisted their presence (García Hierro, Hvalkof et al. 1998).

By the 18th century, Europeans began entering the area with commercial interests, looking for *sarsaparrilla* (*Smilax* species) which was in high demand in Europe as a treatment for syphilis. Europeans were also interested in the bark of the quinine tree (*Chinchona officinalis*) to treat malaria (Hvalkof 2003). Indigenous groups, like the Yine[13], entered into commercial relations with European merchants as guides, and even raided and sold members of other ethnic groups as slaves. As a result, inter-ethnic relations in the area grew tense and there was a lot of brutality (Hvalkof 2003).

In the 19th century, the Ucayali region saw the appearance of rubber barons who captured indigenous people and forcefully relocated them to other areas for rubber tapping. During these

[13] Also known as Piros.

three centuries, the indigenous population of the Ucayali region was decimated by epidemics, slave raids, and interethnic warfare resulting from the increasing contact with Europeans[14].

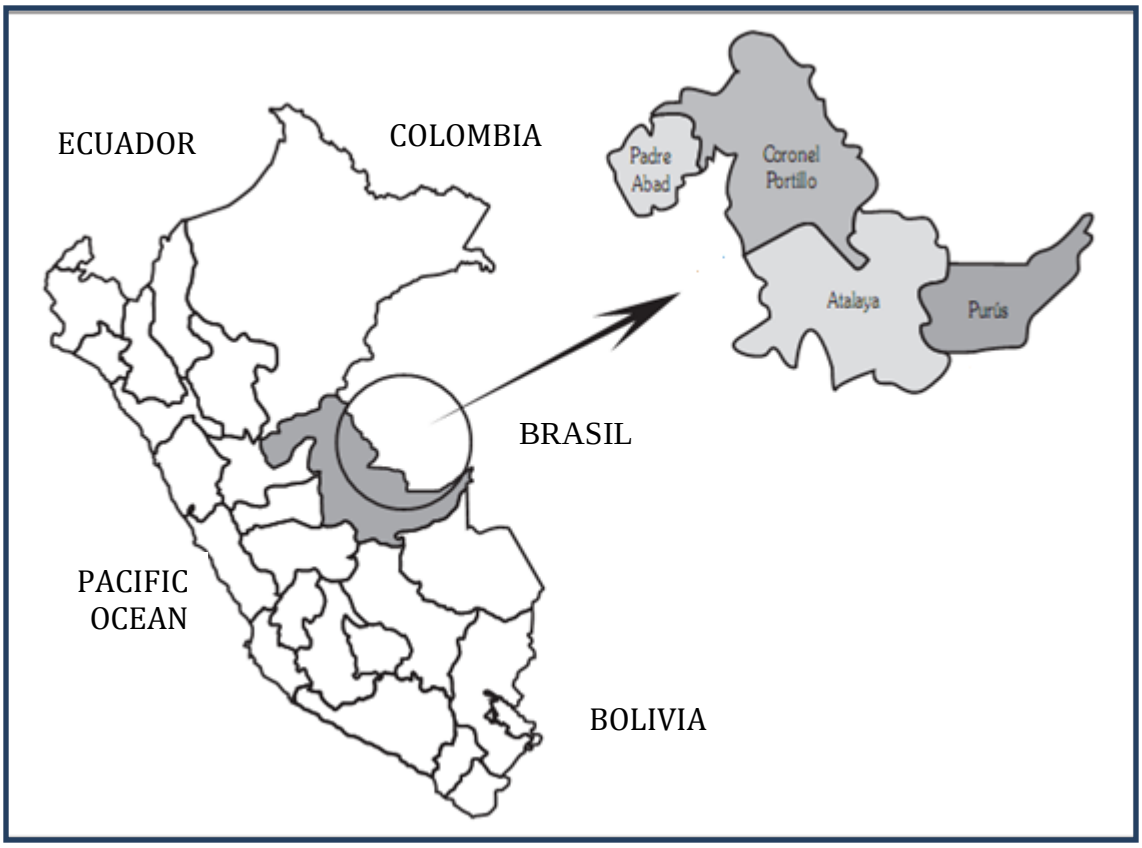

Figure 2. Location of the Ucayali region in Peru and its four provinces [15]

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The growing inroads made by European settlers gradually opened the area up for colonization. When the rubber boom ended in 1915, many rubber barons settled in the area, establishing haciendas for cattle ranching, agriculture, and companies for timber extraction (Parellada and Hvalkof 1998). These activities created new demands for indigenous labor that led to further slave raids and the illegal annexation of indigenous land for agriculture. These

[14] For example, in 1644 smallpox killed 85% of the Cocamas and the Setebos, once a numerous ethnic group. The group was reduced to around 1000 individuals by the 18th century. Myers T.P (1988).

[15] Adapted from: Guevara Salas, S. (2009). Ucayali: Un análisis de situación en población. Lima, Fondo de Población de las Naciones Unidas, UNFPA y Consorcio de Investigación Económica y Social, CIES

inhumane and illegal practices continued in the Ucayali region until the mid-1980's, as documented by this letter from a local indigenous community to a fact-finding commission:

> The native community of Diobamba, on the left bank of the river Ucayali, Raymondi district, Atalaya province, wish to denounce the actions of César Cagna Figueroa. We have agreed to complain about the abuse and outrages we have suffered for many years at his hands. He has taken our land away from us in two places: firstly the 'Chanchamayo' estate. He does not work here, he just lives to exploit and deceive us in our work. He has appointed himself Chief of the native community and we are compelled into forced labour. He does not let us talk or laugh. If we stop working or speak, he threatens to hit and beat us. He often kicks and punches us."(García Hierro 1998:23, from the English version of the book)

The continuance of such abuse of the indigenous population almost 150 years after Peru obtained its independence in 1821 prompted indigenous people to organize and begin the first indigenous organizations in the Ucayali region (Hvalkof 2003).

With the logistical and financial support of International Work Group for Indigenous affairs (IWGIA) and the Danish International Aid Agency (DANIDA), local indigenous organizations and communities in Atalaya province established legal community boundaries throughout the 1990s, and exerted pressure on the government to provide official land titles and give serious consideration to indigenous problems in the region (García Hierro 1998).

1.7.1.2 UCAYALI REGION AND ATALAYA PROVINCE – CURRENT STATUS

The Ucayali region occupies approximately 8% of the Peruvian national territory (INEI 1993), and consists mostly of tropical rainforest. According to the 2007 National Census, the total population of the region is 432,159 inhabitants, which represent 1.6% of the total Peruvian population (INEI 2007). Ucayali is a sparsely populated region (only 4 persons per km^2) and 82.9% of its population identifies itself as *mestizo* (INEI and UNFPA 2007; Guevara Salas 2009).

The population of the region has increased as a result of internal migration throughout the 20th century. The regional population quadrupled between 1940 and 1960, and again doubled between 1960 and 1970, mostly due to migrants from the Andean region looking for agricultural land for food crops (Guevara Salas 2009). In the 1980's and 1990's the population grew at a much slower pace fueled by migrants in search of land for coca cultivation (Perez, Aramburú et al. 2003).[16] The Ucayali region is one of the largest suppliers of commercial timber in Peru, producing 42% of the lumber and 32% of laminated and plywood products (García Hierro, Hvalkof et al. 1998).

The population of the Atalaya province is 43, 933 inhabitants (INEI 2007). The total area of the province is 38,924.43 km^2, comprising 38.01% of the Ucayali region (MEM and MPA 2007). Its population growth rate has varied over the years, but the largest population increase occurred between 1981 and 1993 due to agricultural migrants relocating from the adjacent region of Junín in the Andes (MPA 2007).

Almost 65% of Atalaya province's population is rural (INEI 2007), and according to health authorities 49% is indigenous (DIRESA-UCAYALI 2011). The major economic activities in the province include agriculture, cattle ranching, logging, and hydrocarbons[17] mining. In indigenous communities, the major economic activities are agriculture and small-scale cattle ranching (INEI 2011). During my research, I observed some communities enter into agreements with local loggers to extract timber from community land.[18]

[16] In 1994, more than 21,000 hectares were used for illegal coca cultivation in Ucayali UNODC and DEVIDA (2011). Perú - Monitoreo de Cultivos de Coca 2010. Lima, UNODC y DEVIDA.
[17] Natural gas and petroleum.
[18] These agreements were often disadvantageous for the communities. For example, while I was in the field in the Nariteri community in 2011, I learned that the loggers paid the community chief with one second-hand electric chainsaw and 500 soles (around 200 USD) to cut trees for over a year **(personal observation)**.

Atalaya is one of the poorest provinces of Peru (Guevara Salas 2009). It is classified as a province in "extreme poverty" by the Peruvian Government because of a high level of undernourished children, high percentage of people without access to water and sanitation services, limited number of health facilities, and limited access to electricity (MEF 2000).

1.7.2 INDIGENOUS GROUPS AND COMMUNITIES

Comunidades Nativas (CCNN) are state sanctioned indigenous communities with official recognition of communal property rights over land with specific boundaries[19]. According to the Peruvian Constitution, CCNNs are legally recognized as *Personas Jurídicas*. This designation gives them the autonomy to organize internally, make decisions about communal work and use their land as they see fit. The legal protection also guarantees that the communal lands of the CCNNs are inalienable (*imprescriptibles*), i.e. cannot be taken away, unless they are abandoned (Alvarez 2011). Currently, 27.1% of the Peruvian Amazon is designated as CCNNs, whereas 30.4% belongs to businesspersons (people who have bought land to make investments) and *colonos* (colonizers from the Andes) (Guevara Salas 2009). The rest is unoccupied land owned by the Peruvian state.

The indigenous population of the Amazon is estimated to be around 340,000 people (Alvarez 2011). Within the Ucayali region, indigenous people belonging to the Arawak and Pano linguistic families comprise 17.2% of the population and are distributed in 296 CCNNs

[19] Comunidades Nativas came into existence as a result of the 1974 law "Ley de comunidades Nativas y de Promoción Agropecuaria de Regiones de Selva y Ceja de Selva "which was a result of the Agrarian Reform in Peru. Thus, the Peruvian state recognizes property rights over pieces of land used for agriculture, but not land that is forest. This implies that indigenous people's territories are not recognized. Property rights over specific land plots are given to indigenous communities organized as a Comunidad Nativa.

(DIRESA-UCAYALI 2011). According to the Ministry of Health, 34% of all Amazonian indigenous people live in Ucayali (MINSA 2010).

There are 146 CCNNs located in the four districts of the Atalaya province: Raymondi, Sepahua, Tahuanía and Yurúa (DIRESA-Ucayali 2010); indigenous people represent almost half of the province's population (DIRESA-UCAYALI 2011). Of the nine indigenous groups that live in the Ucayali region, five - the Yine, the Nahua, the Amahuaca, the Asháninka and the Shipibo-Conibo - are present in the Atalaya province (Guevara Salas 2009).

Table 9. Indigenous groups in the Ucayali Region

Linguistic Family	Indigenous Group	Ucayali Provinces where indigenous groups live			
		Atalaya	Coronel Portillo	Padre Abad	Purus
Arawak	Asháninka	■	■		
	Culina				■
	Yine	■			
Pano	Amahuaca	■			■
	Cashibo-catacaibo	■	■		
	Cashinahua				■
	Nahua	■			
	Sharanahua				■
	Shipibo-conibo	■	■	■	

Adapted from: Instituto del Bien Común. Sistema de Información sobre Comunidades Nativas de la Amazonía Peruana (SICNA)

In the following section, I will describe the three ethnic groups I interacted with during my research.

1.7.2.1 THE NAHUAS

The Nahuas are a Panoan-speaking indigenous group that lives in the headwaters of the Purús, Manu and Mishagua rivers basins in southeastern Peru (Feather 2004). The Nahuas that live in Atalaya are called the "Sharanahuas" or "Sharitas" (diminutive of Sharanahuas) by the local people. The term means "beautiful people". However, this group is officially known in the

anthropological literature as Nahua and is part of a broader set of indigenous groups which include the Yaminahuas, the Marinahuas, the Cashinahuas and the Chitonahuas. For example in the excerpt below, Feather (2009) explains how the different Nahua groups broke up due to tense interrelationships.

> [Nahuas] do not represent a coherent ethnicity, but instead are local groups of the same Purus-Panoan complex that have broken up and united with a different local group from a new village. Many of these fissions and fusions resulted from the traumatic consequences of the rubber boom but also (...) were a response to internal tensions and conflicts. (p.74)

The term Nahua means "outsider" in contrast to Yora or Yurúa which means literally "flesh" or "body"(Feather 2009). Indigenous people from this group prefer to use the term Yora to refer to themselves, rather than Nahua (Mora, Zarzar et al. 1997). However, the Nahuas of Atalaya have accepted that others use the term Nahua to refer to them. They also now use the term Nahua to refer to their own ethnic group (Feather 2009). Most anthropological texts also use the term Nahua to refer to these groups.

The area the Nahuas occupy in Atalaya is rich in natural resources and "since 1950s attracted increasing number of loggers and oil companies, as well as missionaries attempting to 'contact' them. There were frequent violent clashes between the Nahua, loggers and oil-prospecting teams" (Feather 2009:72). As a result of such clashes, the Nahuas were considered a violent nomadic people by *mestizos* in Atalaya, with little or no knowledge of horticulture.

The contact with outsiders, such as missionaries, loggers and employees of hydrocarbon projects, has been a traumatic process for the Nahuas (Rummenhoeller 2007). In 1984, four Nahuas were captured by loggers and taken to the town of Sepahua. Until then they were considered by the Peruvian government as one of the few remaining "uncontacted" (*no*

contactados) tribes in the Amazon[20]. Following this contact with the outside world, after centuries of being in voluntary isolation, around 60% of the Nahua population was lost (Hill and Kaplan 1989) A MoH report noted:

> The contact of loggers with three Nahua Indians in 1984 led to an epidemic of respiratory infections that developed into pneumonia in the rest of the population. The pneumonia was in addition to preexisting parasitic infections, malaria and gastrointestinal problems. Since then, the Nahua began to rely more and more on outside people for goods and services they needed in their new [sedentary] lifestyle (salt, canned food, noodles, various goods, clothing, medicines, medical support for new diseases, guns and engines). Since that date, their world and everyday life was totally changed [21] (MINSA 2008).

In 1990, promoted in part by Catholic Missionaries, Nahuas settled in a community that I will call "Sharita". Sharita was my first field site. In 1990 their territory became part of the Kugapakori Nahua Reserve which was established by the Peruvian state "to protect the lives, rights and territories of indigenous peoples in South East Peru avoiding, or strictly limiting their contact with national society" (Feather 2004).

All indigenous settlements located within the Kugapakori Nahua reserve fall under the "area of influence" of the Camisea Project.[22] The Camisea Project is a natural gas extraction project headed by Pluspetrol (an Argentinean company) (Feather 2002; MINSA 2008). This project is the first large-scale natural gas project in the Peruvian Amazon and 74% of the gas reserve is located within the Nahuas' traditional domain (MINSA 2003).

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[20] The Sharanahua used to be considered an "ethnic group in voluntary isolation" (g*rupo étnico en* a*islamiento voluntario*) . They are now designated as an "ethnic group in initial or recent contact" (g*rupo étnico en contacto inicial o contacto reciente*). These are categories used by the Peruvian government to classify indigenous communities from the Amazon and grant them special protection rights (MINSA, 2008)

[21] El contacto de madereros con tres indígenas nahuas en 1984, produjo, en el resto de su población, una epidemia de infecciones respiratorias que se complicaron en neumonía, sumándose a las parasitosis, paludismo y problemas gastrointestinales que ya padecían. Los nahuas desde entonces empezaron a depender cada vez más de la gente foránea a su grupo para obtener bienes y servicios que necesitan en su nueva condición (sal, enlatados, fideos, diversas mercancías, vestimenta, medicinas, apoyo médico para las nuevas enfermedades, escopetas y motores). Desde esa fecha, su mundo y cotidianidad ha cambiado totalmente.

[22] An "area of influence" refers to the area that would be affected by the activities of a particular project according to its environmental and social impact assessment reports.

Indigenous groups who have lived for a long time in voluntary isolation from other indigenous groups (as a result of traumatic experiences mostly during the rubber boom) and who had been "re-contacted" recently, usually suffer epidemics of diarrheic or respiratory illnesses (Huertas Castillo 2007). Such epidemics become more frequent once communities settle in one place and foreigners enter their territory. Frequent epidemics reflect the existing risks over the demographic equilibrium of these populations (Huertas Castillo 2007). The vulnerability of the Nahuas led to the construction of a health post in 2009 in the community of Sharita. It was at this health post that Hugo, one of the INTs I visited, was working during my fieldwork.

One characteristic of the Nahuas is their mobile lifestyle, which consists of journeys through towns and forest (Feather 2009). Feather argues that just as Nahuas travel –physically– to other places, they also do it spiritually and travel through body and spirit, present and past (Feather 2009). Given that there is no specific information about the Nahuas' medical system, I will be using information about the Cashinahua medical system to provide an overview of specific medical concepts of this Panoan-speaking group.

The concept of the body among the Nahuas and the Cashinahuas (who have been more studied) is crucial in understanding aspects of their ethnomedical system. McCallum (1996), for instance, explains that the Cashinahua body is the place in which social and supernatural processes coalesce. The body for Cashinahuas "is made by others in a constant flow involving nutrition, abstention, the application of medicines, body painting, baptismal rituals, and formal training (McCallum 1996:352)". Thus, when a woman is pregnant, both the father and the mother of the baby must follow a specific diet since what they eat affects the shape and growth of the fetus (McCallum 1996). Following these ideas about the body, Feather (2009) found out that according to Nahua cosmology, illnesses are caused by 'others' in the form of spirits of

animals or other beings. The cure to illnesses he explains, can be found both in pharmaceuticals (which they obtain in Sepahua or at the Health Post) and in the domain of shamanism.

Lagrou (2004) explains that among the Cashinahuas there are herbal doctors and poison owners (herbal doctors' counterparts). Herbal doctors know a large range of plants which they use to heal (Kensinger 1998). According to Cashinahuas, illnesses can have two possible origins, either natural or spiritual. Natural illnesses are considered part of the lifecycle, just as birth, old age and death. Natural illnesses are treated by the herbalist. However, when the sick person does not respond to the herbalist's treatment, people suspect that the illness is caused by the spirits who have been offended or who are acting on behalf of a sorcerer (Kensinger 1998). It is in these cases that the family members of the sick person resort to a shaman, who will go into trance to identify the cause of the illness (Kensinger 1998).

Cashinahua shamans use various plant substances (such as Ayahuasca[23] and tobacco) to alter perception (Lagrou 2004). They also apply the extract from a sacred plant into their eyes to visualize pathogenic agents they extract them from the bodies of their patients (Lagrou 2004). Feather (2009) explains that among the Nahuas of Atalaya, drinking Ayahuasca is not an exclusive activity of shamans. Based on his informants' accounts he realized that Ayahuasca sessions are represented as journeys during which each person sings a *rabi*; a non-curative song "that describe an upward journey into the world of the owners of the *shori* [Ayahuasca]" (p.79).

[23] Ayahuasca is a hallucinogenic drink made from the stem of the ayahuasca vine, Banisteriopsis caapi. The ayahuasca drink is sometimes, but rarely, made from the ayahuasca vine alone; almost invariably other plants are added (Beyer 2009). The most common preparation of ayahuasca is the concoction of Banisteriopsis caapi plus Psychotria viridis (Luna 2011). The ritual use of ayahuasca is a common thread linking the religion and spirituality of almost all the indigenous peoples of the Upper Amazon (Beyer 2009). The Upper Amazonian religious culture area is characterized by a number of common features — the use of psychoactive plants; the presence of magical substances kept within the shaman's body; notions of sickness as caused by the intrusion of pathogenic objects projected by an enemy or sorcerer; the ambiguity of shamanic ability to do both good and evil; the central sacrality of tobacco; the acquisition of songs from the spirits; the use of songs for the creation of both medicines and poisons; a focus on healing with the mouth through blowing and sucking; and the importance of sound — singing, whistling, blowing, and rattling — in both healing and sorcery (Beyer 2009).

When Ayahuasca is drunk in the context of a healing ritual with a shaman, the *rabis* are followed by curing songs (*koshuiti*), sung by shamans who are trying to heal a patient (Feather 2009).

The Cashinahua of the Purús River classify shamans into two groups. The first group is the *dauya*, the one with medicine, who kills and heals through the use of medicinal plants. The second group is the *mukaya*, who heals and kills with the help of the *yuxin*, spirits, using a bitter substance called *muka,* which is the materialization of *yuxin* power (Beyer 2009). Similarly, Kensinger (1998) explains that there are two types of medicine among the Cashinahua; sweet medicine or "*dau bata*" and bitter medicine or "*muka bata*". *Dau bata* is associated with herbalists who heal using medicinal plants he collects from the forest or from his own medicinal garden. On the other hand, *muka bata* is associated with a healer that has gained knowledge about plants from spirits. As such, this kind of healer treats illnesses caused by sorcerers or by a spirit who has been offended (Kensinger 1998).

According to Lagrou (2004), scholars affirm that the Cashinahuas believe they have lost all their powerful specialists – sorcerers and shamans alike. A possible explanation for such affirmations is that they want to protect the knowledge held by shamans, herbalist and sorcerers from outsiders (Lagrou 2004). By telling researchers that there are no shamans or sorcerers in their communities, they avoid talking about them and providing information about their healing rituals and medical systems.

1.7.2.2 THE SHIPIBOS

The Shipibos are also known as Shipibo-Conibo. The term Shipibo is used to describe a kind of monkey called "Shipi." The word Shipibo means "men that look like small monkeys" (Cárdenas Timoteo 1989). Franciscans who entered the area in 1657 to establish a mission, mistakenly called the Shipibos "Calliseca" (which is a different ethnic group) (Myers 1974).

Until the 16th century, Shipibos and Conibos were two distinct ethnic groups; however, the rapid decrease in population that resulted from the colonial encounter forced both groups to come together as allies to fight outsiders. The two groups eventually became known as one group called the Shipibo- Conibo (Reategui Silva 2003). Shipibo-Conibo belong to the Pano linguistic group, which extends into Brasil, Bolivia and Peru. In Peru, there are currently 10 Pano-speaking ethnic groups, which represent 30,409 people (Morin 1998). Shipibo-Conibo are the most numerous ones since they represent 22,517 (74%) of all Pano-speaking groups (INEI 2011).

Historically, the Shipibo-Conibo dominated the plains along the Ucayali river (see Figure 3); Ucayali means "the mosquito river" in the Shipibo language (Hvalkof 2003). Currently Shipibo-Conibo occupy the valleys of the Ucayali river and its tributaries (Foller 1989; Hvalkof 2003). Historical accounts documented by Franciscans and Jesuits state that Shipibos were warriors who attacked other groups in search of slaves and women, and dominated most of the Ucayali river for centuries before the arrival of Europeans, although no exact dates are provided (Morin 1998). The missionary accounts state that the Shipibos developed a culture that was strongly connected to the rivers, fluvial plains and the wet (flooding) season[24] and the dry season[25] in the years before European encroachment (Morin 1998).

Conibos (unlike Shipibos) were not warriors. The Conibos developed excellent fishing and horticultural abilities in the fluvial plains of the Ucayali river, hunting only during the rainy season when the land was flooded and wild animals took refuge on higher ground (Hvalkof 2003). After the Shipibos and the Conibos became known as one ethnic group they were known as travelers and merchants, having commercialized products like salt among different ethnic groups (Reategui Silva 2003).

[24] Between October and February
[25] From April till September

The first contact between Europeans and the Shipibo-Conibos occurred around 1542 and was violent; Shipibo-Conibo fought foreigners who entered their territories (Bodley 1972; Mora, Zarzar et al. 1997). In the mid-17th century, Jesuit missionaries and soldiers began to explore the Ucayali river, entering indigenous territory where they suffered attacks and were sometimes killed by armed groups of Shipibos and Cocamas[26] (Morin 1998; Reategui Silva 2003). Shipibos expelled missionaries from their land in 1657, however, wars and epidemics during the second half of the 17th century decimated the Setebos, Shipibos and Conibos who inhabited the Ucayali river (Morin 1998).

As a result of the rapid decline in population, with only three thousand Shipibo-Conibos remaining, the population was reduced to two "pueblos" in 1661, where they were being forced to live in a permanent settlement under European control (Guevara 1999). In 1670, they revolted against missionaries, only to fall under Jesuit control again in 1686 (Guevara 1999). By 1689 all the priests had been killed, and missionaries did not return until 1765 when they were able to establish more permanent positions in Shipibo territory (Guevara 1999).

Throughout the century following Peru's independence in 1821, the Shipibo-Conibos experienced a slower and less violent process of assimilation (Guevara 1999). Shipibo-Conibos were subject to the excessive violence of the rubber boom (1860-1915), where many indigenous people were enslaved and taken to other areas to work for rubber tappers (Coomes and Barham 1994). Some Shipibo-Conibos acted as middlemen and helped rubber barons capture the members of other indigenous groups in exchange for tools. Later, after the rubber boom was over, the Shipibo-Conibo who remained along the Ucayali river had to deal with increasing

[26] Cocamas are another ethnic group from the Ucayali area.

pressure on land and natural resources due to the arrival of *colonos* from the Andean region (Foller 1989).

The forced interaction between Shipibo-Conibos and Western society that has occurred since the 16th century together with their dispossession from their territory, has resulted in Shipibo-Conibo culture undergoing deep transformations (Foller 1989). Myths of creation and the supernatural are often fragmented and are different or conflict with one another from one village to the next. There are also traces of both Native and Christian elements in their mythological stories (Eakin, Lauriault et al. 1980). Nevertheless, the Shipibo-Conibo continue practicing several traditions such as language, arts and crafts, the women's way of dressing, eating habits, and their medical system (Foller 1989). Shipibo-Conibo are still recognized as good fishermen, hunters and craftsman, especially women who nowadays travel to different Peruvian cities selling their traditional embroidery, pottery and painted cloth (Reategui Silva 2003).

Foller (1989) explains that Shipibo-Conibo's current medical system is probably a combination of different medical systems: their own, the one brought by Spaniards, as well as elements of medical systems from other ethnic groups. Foller argues that "It is often quite impossible to define how knowledge has been gained and how elements from their cultures have been transformed and adapted - or contaminated - during the historical process" (Foller 1989:813). It is probably the capacity to adapt and incorporate elements and concepts from other medical systems that has helped the Shipibo-Conibo medical system preserve its vitality or relevance over the years.

The Shipibo-Conibo medical system is similar to that of other Amazonian ethnic groups. It uses a combination of dietary restrictions, medicinal herbs, and requires shamanistic oversight

to combat disease (Eakin, Lauriault et al. 1986). Shipibo-Conibos know a large number of curative herbs and are recognized as having the most ethnobotanical knowledge by neighboring ethnic groups (Lanaerts 2006). Some of the medicinal plants Shipibo-Conibo use are cultivated, and other medicinal plants they use grow wild in the jungle (Eakin, Lauriault et al. 1980). When somebody is sick, herbs can be specifically prepared by an herb doctor. At other times the herbs are brewed at home and administered according to medical tradition (Eakin, Lauriault et al. 1986).

The following is an excerpt from a final report written by a Shipibo-Conibo student from AIDESEP's program. The student explains the different understanding that the Shipibo-Conibo have of medicine.

> We believe that everything is alive, has a role in the universe and therefore deserves respect, as there is a visible world we inhabit and there is an invisible world that is inhabited by the spirits of plants and animals. In our culture plants and animals have the ability to think, feel and act and pass on their knowledge through visions triggered by "master plants" as Ayahuasca, the Toé, and snuff (Tobacco) juice. Anybody who consumes these master plants would have visions but only specialists undergoing a rigorous preparation may travel to this sacred world and get their people, their knowledge and powers that allow them to heal the sick [27] (Ferrari 2008)

This quote explains an important characteristic of the way plants are classified in Amazonian indigenous medical systems: these are both "regular" plants (that may or may not be medicinal) and "master plants". Master plants are different from medicinal plants. There is a wide diversity of medicinal plants and they are used in different ways by different ethnic groups. The master plants are "pan amazonic" and are used in similar ways by all ethnic groups (Ferrari

[27] Nosotros creemos que todo tiene vida, cumple un rol en el universo y por lo mismo merece respeto, como existe un mundo visible que habitamos nosotros, existe un mundo invisible que es habitado por los espíritus de las plantas y animales, considerados en nuestra cultura que tienen la capacidad de pensar, sentir y actuar, transmiten sus conocimientos a través de las visiones provocadas por plantas maestras como el ayahuasca, el toé, el jugo del tabaco en todas las personas que las ingieren. Pero solo los especialistas tras una rigurosa preparación pueden transitar a este mundo sagrado y obtener de sus habitantes, sus conocimientos y poderes, que les permiten sanar a los enfermos.

2008). One of such "master plants" is Ayahuasca. Different indigenous groups prepare Ayahuasca in different ways (Reichel-Dolmatoff 1975). Furthermore,

> [i]t is relevant to point out that indigenous groups distinguish several "kinds" of vines to refer to what western botanists see as just one species. This means they have a much more refined taxonomy, based not only on the morphology of the plant, but also on its effects, which may differ according to the type of soils it grows, the part of the plant used, the season and the moon in which the vine is harvested, and other factors (Luna 2011).

Besides master plants, another pan-Amazonian tradition are dietary restrictions, which are usually part of medical treatments or the training for those who want to become shamans or healers (Reategui Silva 2003; Luziatelli, Sorensen et al. 2010).

Shipibo-Conibos perceive a close relationship between food and illness. As Eakin et al explain, "various food restrictions are enforced during sickness, either at the suggestion of the herb doctor or shaman or as dictated by general tribal lore" (Eakin, Lauriault et al. 1986:43). Eakin et al (1986) describes how the patient is expected to follow a diet to recover his/her health and family members also have to restrict their eating. Failure to do so might aggravate the illness. Similarly, during a community health study in a Shipibo village in Peru in 1976, Hern (1992) found that almost all Shipibo remedies were accompanied by food prohibitions or other taboos.

> "I asked Julia [his informant on traditional medicine] what other things were done while taking *tootimahuaste* [contraceptive plant]. The woman taking the remedy, she said, could not eat ripe plantains, could not eat sweet substances such as honey or sugar, could not eat several other things, and she could not have sex." (p.5)

The set of Shipibo-Conibos restrictions prescribed can be nutritional, sexual and/or social. Shipibos-Conibos who are attempting to become *Onayas* (shamans) ought to consume mostly fish and boiled plantain and avoid salt, butter, chilies, sugar and pork (Caruso 2005).

While trying to learn about the healing power of specific plants, they might have to follow other restrictions. Caruso (2005) notes it is interesting that the foods to be avoided by shamans (and healers) are those that were introduced by foreigners (such as pork, salt and sugar). Caruso also said there is probably a symbolic connection between foreign food and traditional healing power[28] (Caruso 2005).

1.7.2.3 THE ASHÁNINKA / ASHÉNINKAS

Ashaninkas and Ashéninkas belong to the Amahuaca (also known as Arawak) linguistic family. The term "Asháninka" means "our fellows" or "our kinfolk" (Salles-Reese and Vergara 2009). The difference between Asháninkas and Ashéninkas is linguistic given that they speak a different dialect of the same language. The dialects are mutually intelligible but there are also important differences (Hvalkof 2003). Hvalkof (2003) explains below the similarities between the Asháninkas and Ashéninkas:

> [The Asháninkas and Ashéninkas] belong to the same cultural group and are considered one ethnic group that shares several cultural patterns such as cosmology, material culture, religious practices and economic patters but live in different geographical areas (p.46).

The Ashéninkas occupy mostly interfluvial areas like "El Gran Pajonal" in the Atalaya Province which extends into the neighboring Junín and Pasco regions.

Asháninkas live along the Apurímac, Ene, Tambo, Perené, and Pichis rivers, as well as along the northern section of the Ucayali river, at the foothills of the Andean region (Mora, Zarzar et al. 1997; Luziatelli, Sorensen et al. 2010). Varese (2003) explains that Asháninkas who

[28] I remember that during my fieldwork while I was in Oventeni in 2011 (the Ashéninka community) I was told that witches who escape and migrate to the city after being expelled from their community, stop being witches when they begin consuming "mestizo food" such as onions, garlic and spices ("*condimentos*").

live near the main rivers rely more on fishing and hunting, while Ashéninkas rely more on horticulture.

Most official data combine Asháninkas and Ashéninkas under the term “Asháninka”. There are Asháninka communities in six of the 24 Peruvian regions and most of them are located in the Ucayali region (Mora, Zarzar et al. 1997). The communities of Asháninkas who live at the foothills of the Andean region are relatively clustered, while in the Ucayali region, Asháninkas live in small scattered communities surrounded by mostly Pano-speaking communities (Hvalkof 2003).

Asháninkas are the largest indigenous group from the Amahuaca linguistic family. There are 88,703 Asháninkas in Peru, representing 26% of the indigenous people from the Peruvian Amazon according to the 2007 census (INEI 2011). Asháninkas are also known as “Campas” which is considered a derogatory term by Asháninkas “because it derives from the Quechua *thampa*, which means ragged and dirty” (Salles-Reese and Vergara 2009:70). Another explanation of the origin of the term “Campa” is provided by Varese (2003) who explains “Camba means "black" or "little black person" in Tupi-Guraní” a rival indigenous group (p. 36). In Brazil, Asháninkas are called “kampas” and were probably taken from the Gran Pajonal area to Brazil by rubber barons (Mora, Zarzar et al. 1997).

Asháninkas, like most indigenous groups of the Peruvian Amazon, have experienced a long history of territorial dispossession. Territorial invasion of Asháninka lands dates back to the 16th century when a European expedition lead by Juan Velez was the first attempt to colonize the area currently known as the *Selva Central*, the forest at the foothills of the Andes (Salles-Reese and Vergara 2009). Later in that century Franciscan and Dominicans attempted to build Missions in Asháninka territory, although they were expelled from the area in 1750 by way of an armed

rebellion on the part of an interethnic alliance of Yines, Yaneshas, Mocobos, Simirinche and Shipibo-Conibo (Reategui Silva 2003; Salles-Reese and Vergara 2009). For almost one century the *Selva Central* was inhospitable for Spanish and missionaries (Reategui Silva 2003).

By the mid-19th century, Asháninkas had to retreat again due to increased harvesting of rubber and wood, as well as "the capillary invasion of tribal lands by dispossessed Andean peasants" (Varese 2003:14). From the Asháninkas point of view, the 150 years from the beginning of the nineteenth century to the 1950s can be outlined as a period of little incursion followed by more incursion during the rubber era as follows:

> "(1) [A]n initial period of approximately forty years, during which there was no official attempt at reconquest and even European travelers, like later ethnologists avoided their territories; (2) a period of approximately sixty years that witnesses alternating "civil" and "missionary" expeditions, which in reality, save rare exception, can be classified as intimidatory military missions resulting in white incursion that typifies the third stage;
> (3) the rubber era, which covers the first fifteen years of the twentieth century." (Varese 2003:112)

The end of the rubber boom did not bring peace to Asháninkas since –as explained earlier- many exploitative practices continued in the Ucayali Region. Furthermore, in the 1980s, Asháninkas from the *Selva Central* were victims of the political violence of the Shining Path, which forced around 5000 Asháninkas to leave their communities. The Shining Path kept about approximately 5000 Asháninkas captive as slaves (*esclavos*) and 6000 Asháninkas were killed in clashes with the Shining Path according to the Truth and Reconciliation Commission (CVR 2004). In the late 1980s, Ashéninkas from the *Gran Pajonal* area organized a militia group called "*Ejército Asháninka*" and managed to kill and expel Shining Path from their territories and prevent the Peruvian army from entering (Hvalkof 2003).

Over the centuries, the Asháninkas have been forced to retreat to smaller and smaller ranges of territory where the quantity and quality of land is poorer, thus affecting their

agricultural production (Varese 2003). Asháninkas (like most tribal populations of the tropical rain forests of South America) practice slash-and- burn agriculture, and yuca is the most important plant in their subsistence economy (Varese 2003). Yuca is called *kaniri* in their language and it constitutes the basis of Asháninkas daily nutrition. Yuca is consumed boiled, barbequed "or as a fermented beverage called *piarintzi* in Campa and *masato* in the Spanish spoken in the jungle" (Varese 2003:8).

Subsistence agriculture is the main economic activity of the Asháninkas who also cultivate plantains, corn, peanuts, sachapapa, pituca, sweet potato, rice, beans, citrus fruits, sugar cane, pineapple and other tropical fruits (Mora, Zarzar et al. 1997). In Nariteri, the Asháninka community I visited did not have such a wide diversity of products, however. People mostly ate yuca with fish, game meat and chickens or ducks are kept for their eggs. Masato is an everyday beverage consumed even by small children as young as one year old.

As hunters, fishermen and gatherers, most of Asháninkas' worldview has to do with the relationship between human beings and nature (Reategui Silva 2003). They have strong beliefs about punishments for people who hunt or fish excessively; punishments caused by animals and fish (Reategui Silva 2003). Various Amazonic groups have similar rules prohibiting or restricting consumption of game: "Some species are never eaten, while others are temporarily or permanently mandated or prohibited to the entire community, to specific groups, or to individuals" (Meggers 1971 (1996):175).

I was able to corroborate that Asháninkas believe in witchcraft during my stay in Nariteri, one of the field sites I visited in 2011[29]. According to Rojas (1994), a person who is suspected to

[29] Throughout my time in this community I was told several stories where one person used witchcraft on another, and even stories where the community killed an old man they said was using witchcraft to make young girls fall in love with him

be a witch is one who is not generous or reciprocal in the distribution of food as expected (Rojas Zolezzi 1994). Varese (2003) further explains how generosity is an important part of socialization for the Asháninkas:

> A man who does not give generously to others is not a completely "socialized" individual; he is tacitly shunned by his society. A child has to learn the rules of this game from a very tender age because not following customs and etiquette -not respecting the guests, not giving him food, or not trading generously with him - means breaking this flow that unites people; it means breaking communion, an offense against society itself (p.34)

Sheripiaris (the local term for shamans) can solve problems caused by lack of generosity and also health problems. Asháninka sheripiaris use various substances to help treat these conditions:

> [They] use tobacco and some hallucinogens to enter trances that will allow them to communicate with the supernatural. Illness is cured with the help of steam baths, magical herbs, and sessions with the healer, who tries to send the disease back to the one who originated it (Salles-Reese and Vergara 2009).

Sheripiaris have to undergo long periods of training during which they follow a strict diet where they can only eat cold vegetables (no meat). The only fish they are allowed to eat is the *boquichico* (*Prochilodus nigricans*) because this fish feeds by sucking small fishes from the mud in the river shore; *boquichicos* suck small fishes just as shamans will need to suck illnesses from people when they are ill (Rojas Zolezzi 1994). Asháninka sheripiaris traditionally used tobacco to heal; *sheri* means tobacco and sheripiari means “tobacco drinker”, Ayahuasca is considered to be a later incorporation into their healing tradition (Luziatelli, Sorensen et al. 2010)

1.8 FIELDSITES

The five fieldsites I visited during my fieldwork were: a Nahua community, a Shipibo-Conibo community, an Asháninka community and two towns. I will use pseudonyms for all the visited communities. The towns where I conducted field research were mostly inhabited by *mestizos;* however, on a daily basis indigenous people from the surrounding Asháninka and Shipibo-Conibo groups would come seeking health care or to sell some products. In the following subsections, I provide an overview of the communities and towns visited, as well as the health services available. As we will see in Chapter 4, the intercultural health approaches that were the focus of my research can only be understood if one has a grasp of the way health services are structured in rural Peru.

1.8.1 SETTLEMENT SHARI

The Nahua settlement I visited was called Shari. Shari was not a CCNN since it is located on a national reserve and the inhabitants have not yet organized to legally register their land. Shari is a settlement of 39 families located in the confluence of the Mishagua and Serjali rivers. Half of the families lived clustered around an area that has been cleared from wild grasses and is used as a soccer field on Sundays. The rest live in houses somewhat isolated from the community's center, but still within walking distance from the other houses. The community does not have electricity or running water, and while I was there, it did not have any means of communication since the ham radio was broken. There was a primary school supported by the Dominican mission. There were four teachers, but only one teacher was bilingual in Nahua and Spanish.

Most children understood Spanish but they preferred to speak in their native language with their families and amongst themselves. Both children and adults wore "western clothes": t-shirts, shorts, skirts, flip-flops. There was only one very old man in the community who still had the traditional haircut (that resembles the Franciscan haircut: long hair with a bald patch at the top of the head) a loincloth (*taparrabo*), several long necklaces and a nose piercing. One of my informants told me that when they were nomads they used to go almost naked, but now they have learned to wear clothes, probably encouraged by the Dominican nuns who arrived there in the 1980s.

Hugo, the INT working at Shari, was the first health worker to ever maintain a permanent position in the community. In the past, health services were largely provided by medical brigades[30] that were sent from the Health Center in Sepahua. The medical brigades would visit Shari every 6 months to provide primary health care.

During an interview I conducted with the son of the Curaca (community's chief), he explained how things were in Shari before Hugo the INT arrived.

> "*Nowadays, when somebody falls ill, we take him/her to the health post. Before, they say they took the ill person to a shaman or a witchdoctor, they would take the patient there and if he was not helpful, the patient's father had to go to the forest and look for a medicinal plant, make it boil and apply it over the body part that was sick.*
>
> *Before there was a nurse technician, we had a health promoter. But his work was volunteer work. The medications we used to have we had to request it from the Mission, because the government would not give us anything. They say (I am not sure this is true) that once the Dr. in Sepahua asked the Gas Company to give several medications for Shari and when the donation arrived, they kept many medications in Sepahua and the rest they sent over here.*

[30] A medical brigade is a team of health professionals, usually a doctor, a nurse and a dentist who would travel to distant communities within a district to provide primary health care such as vaccination and prenatal care.

Young people here do not learn about indigenous medicine. Young people do not want to use it anymore. They also do not want to use bows and arrows, only rifles [31].

This conversation shows that some traditional practices such as the use of indigenous medicine and hunting with bows and arrows are currently being set aside. As I observed during the two months I stayed in Shari, there was a very high reliance on pills and injections distributed at the Health Post. This did not mean that traditional healing practices were not used. During my time in Shari I observed firsthand at least three occasions in which the local healer treated patients for shock produced by the "*tunche*" (the demon) and for stomach aches[32].

1.8.2 CCNN NARITERI

Nariteri was the most isolated community I visited during my fieldwork. It took me two days to get from Atalaya to Nariteri, first downstream on the Urubamba river and then upstream on the Sepa river. Although it was the beginning of the rainy season and the Sepa river had increased its volume, the two people from the community I was travelling with still had to get out of the canoe several times to push the boat until we arrived at a deeper spot in the river.

Nariteri was an Asháninka community of around 30 families. There was a bilingual primary school staffed by two bilingual teachers and an unfinished Health Post. Municipal authorities were waiting for the volume of the river to increase to be able to bring the material for the Health Post's roof by boat to finish the facility. Thus, the INT working there had to see

[31] Cuando alguien se enferma lo llevamos a la posta. Antes, dicen que lo llevaban donde un chamán o brujo. Lo llevaban allí y si el brujo no te ayudaba, el papá tiene que ir al monte a buscar un vegetal para hacerlo hervir y luego apretarle sobre la parte que está enferma. Antes de que venga el técnico, había un promotor, pero su trabajo es voluntario. Los medicamentos los teníamos que solicitar a la misión, el estado no nos daba. A veces también de Sepahua el MINSA nos mandaban un poco. Dicen (no estoy seguro de si es verdad) que el Dr. Luis solicitó varios medicamentos a la empresa para Shari y dicen que se agarraron una parte para Sepahua y el resto lo mandaron. Acá los jóvenes no aprenden la medicina indígena, los jóvenes ya no quieren, tampoco quieren usar flecha, sólo escopeta.

[32] This example will be expanded in Chapter 4.

patients in his house or go and see patients in their homes. He was the first health worker ever to stay permanently in Nariteri.

Water was drawn from the river because there was no potable-water system. There were only four latrines in the whole community, two of which belonged to the school. With municipal support, men in the community had built a cabin with solar panels. On a daily basis, households charged a car battery during the day so that at night they can power a light bulb in their homes.

People in Nariteri eat mostly yuca, fish, plantains, fruits and game meat. Fishing is both a collective and individual activity. I had the opportunity to participate in a fishing trip. The day before the fishing trip, a group of men went up river and added *barbasco* (*Lonchocarpus utilis)* to poison the water and kill the fish. The following day I went together with a group of families to catch the dying fish from the water with arrows and machetes. We were able to catch many fish and they were all taken in big baskets to the community where women spent a long time eviscerating and salting them to prevent them from rotting.

The yuca fields that belonged to the people of the community were located a couple of hours walk – or a couple of hours rowing in a canoe – from the community. Twice a week the women of the household would go to their plot early in the morning and return by noon carrying big piles of yuca in baskets they balanced on their foreheads. Fishing and hunting were also regular activities but mostly done by men. Women prepared *masato* (mandioca beer) not only for special occasions, but for regular consumption. In order to prepare *masato*, women would boil yuca, and mash it with big wooden tools. Afterwards they would take some of the mashed yuca, chew it and spit it back into the mixture to promote fermentation. This could take hours. Water will be added slowly and the mixture would be allowed to sit for a day until it was fermented. Not everybody made *masato* on a regular basis but people were aware of which household had

masato and the households with *masato* would receive visitors who were served the fermented beverage in soup-sized bowls called *pates*.

In Nariteri there was no health post and the INT working there had a small supply of medications. Given the isolation of this community, he could not go to Sepahua on a regular basis to get the monthly allocation. There was an indigenous specialist called Bertha who knew how to heal using vapor from medicinal plants through steam baths. She would first put three to four big stones on a fire and simultaneously (on a separate bonfire) boil medicinal plants in a big pot, but with little water. Once the stones were red hot she would add the stones to the pot containing the medicinal plants. The patient would place his or her face in the steam emanating from the pot and use a blanket to cover and inhale as much vapor as possible. This process, called *vaporación* was used to heal "*mal de ojo*"[33] and also to determine if someone had been the victim of witchcraft. To know if it was witchcraft, Doña Berta would turn the pot upside down after the *vaporación* was completed to check for objects that were left with the stones and the medicinal plants. These "objects" could be fish bones, *masato*, or plastic bags, – she explained – depending on the type of witchcraft that had been done. Doña Berta did not explain this very well, but from our conversations, what I understood was that "foreign objects" such as plastic bags represented that the witchcraft originated outside the community, while local objects such as yuca peels signified somebody in the community was responsible for the witchcraft.

Javier was the first health worker in Nariteri and while there was no official Health Post, Javier told me people felt ashamed of coming to his house asking for medical attention at first. When Javier realized this, he approached the *Jefe* (chief) who used a loudspeaker to explain Javier's work to community members on a regular basis. He explained that Javier's job was to

[33] It was a cultural-bound syndrome that let to intense diarrhea and fast dehydration in the patient. Western medicine would not cure it.

help sick people and that the community members had to allow Javier to help family members who needed medical attention. Javier would also walk around the community visiting people in their homes and to find out who was sick or pregnant. Gossip was a great source of information Javier told me. Somebody in the community would tell him "*the son of so and so had been sick since yesterday, you should go and see him.*" The only problem with this strategy, said his wife, was that people would offer him *masato* in each house he visited, and by the time he came back home he will be "tipsy". I learned through several informal conversations that people in Nariteri were very happy with Javier's work and he became an accepted member of the community. He would be invited to participate in hunting expeditions and other community events.

1.8.3 CCNN SHIPAYA

The Shipibo-Conibo community I visited was called Shipaya; it was located on one small tributary of the Ucayali river, seven hours downstream from the town of Bolognesi[34]. There were around 40 families living in Shipaya, and another 40 in the neighboring *mestizo* settlement (*caserío*), which made it feel like a larger settlement. Shipaya was officially recognized as a CCNN in the 1980s together with the creation of an indigenous organization that brings together indigenous communities in the Tahuanía district (*Organización de Comunidades Nativas del Distrito de Tahuanía* ORDECONADIT)

People from Shipaya obtained fresh water from wells, but there were neither latrines nor a sewage system. Shipaya had a primary school, a couple of *bodegas*[35], a satellite public phone, a

[34] See section 1.7.4 for a detailed explanation of Bolognesi's location.
[35] Small stores where you can buy detergent, canned milk, cookies, sodas, canned fish and even some antibiotics and over the counter medications.

ham radio and – if there is enough gasoline – the community was wired to provide electricity at night in public spaces.

Shipaya has had a Health Post since the 1980s, however, it has not always been able to have a regular health worker to provide services. People told me that some health workers would come, stay for a couple of months, and leave because they did not get used to living there. However, just before Servando, the INT who worked there during my field research, there was a *mestizo* health worker who stayed in the community for about six years.

The community had loaned part of its land to loggers who paid it a monthly amount for permission to cut wood from communal lands. With the money they receive, community members sometimes buy gasoline for electricity. Other times, they used the money to make improvements of the community house (*local comunal*) they were constructing. Most women wore traditional dress (a colorful blouse and a skirt called *pampanilla*) and the traditional hairstyle (long with bangs). Many women in Shipaya spent their afternoons embroidering *pampanilla*s, some for self-use, others to sell. Other women made pottery, which they would also send to Bolognesi for sale.

People at Shipaya would consume fish, boiled yuca and ripe plantains. The availability of fish and game nowadays was difficult during the flood-water cycle. While I was staying at Shipaya, most of the fish people caught were small and after a hunting expedition, my host only brought home one Sajino (*pecari tajacu* - wild pig).

In Shipaya one old man was recognized as a shaman. He would drink Ayahuasca with the ill person (if an adult) or with an adult relative of the sick child in order to identify a person's ailment. I did not have the opportunity to observe a healing session, but people told me that the shaman would sing while under the effects of Ayahuasca. In his vision, he would be able to see

all the different organs in the patient's body. He would be able to see the person´s blood and find where the illness was located and what was causing it. Just as Eakin et al (1986) found in the 1980s, Shipibos in Shipaya used both modern medicine and indigenous medicine:

> "[T]he mixture of the Western and indigenous traditions is seen, for example, when a Shipibo speaks of microbes which have been implanted by evil spirits, or when a patient alternates visits to a medical clinic with visits to the shaman. Western medicine and medicinal herbs are also frequently taken together." (Eakin, Lauriault et al. 1986:42)

This assertion describes a situation similar to what I observed during my time at Shipaya. As I will describe in detail in Chapter 4, there were several occasions in which Servaqndo (the INT) would combine Western medical practices with traditional medicine. For instance in one occasion, Servando prescribed and applied eye drops for a person who had a wood splinter in his eye and who was simultaneously being cured by an herbalist who used tree sap to clean the patient's eye.

1.8.4 THE TOWN OF BOLOGNESI: MESTIZOS, ASHÁNINKAS AND SHIPIBOS

Bolognesi was a small town of 1188 inhabitants, mostly *mestizos* who came from the Andean region (INEI and UNFPA 2007). Bolognesi is the capital of the district of Tahuanía and its health center serves a population of 5265, mostly people from the neighboring Shipibo-Conibo and Ashaninka communities (DIRESA-Ucayali 2010). Bolognesi is located on the Ucayali river, seven hours away from Atalaya, by passenger boat. The passenger boats provide public transportation twice a week and carry both goods and people. The population of Bolognesi is mostly made up from migrants from the Andes, most of whom have commercial

stores that sell processed goods[36] suitable for the long journeys people take to go to Pucallpa (three days by boat) and for the communities where such goods are usually unavailable or very expensive. Bolognesi is also an important center to buy and sell lumber from the surrounding Ashaninka and Shipibo communities (such as Shipaya).

Bolognesi had potable water but no sewage system in place. There was electricity between 6 p.m. and 10 p.m. and some stores have public telephone services (MDT 2012). The Health Center has its own generator that runs on gasoline and can provide 24-hour emergency care. During my time in Bolognesi, the Health Center was staffed by ten health workers: a medical doctor, a nurse, an obstetrician (midwife), a dentist and six nurse technicians (one of them an INT).

While I was conducting fieldwork, the medical doctor, the nurse, the midwife and the dentist working at the health center were *serumistas*. A *serumista* is a health professional doing a mandatory year of service after completing their undergraduate health degree. This year of service is called SERUM, which stands for *Servicio Rural y Urbano Marginal.* It is only mandatory for those Peruvians who study a university-level health profession. All the nurses and midwives who were working in the Tahuanía district were *serumistas.* They shared with me how hard they felt it was to work in an isolated place, lacking the comforts they were used to (TV, running water all the time) and without the basic implements to perform their work such as an x-ray machine or adequate medications. For instance, the dentist told me that all the dental instruments in the Health Center were rusted and he had to use his own medical instruments.

Serumistas were mostly from the city of Huancayo (from the Junín region which neighbors Ucayali) and from Pucallpa. None of them knew about indigenous people before

[36] Such as pasta, canned fish, crackers, bread, oil and canned milk.

being sent to Tahuanía and they had a hard time adapting to providing services for people they could not understand because they spoke a different language.

1.8.5 THE TOWN OF OVENTENI: ASHENINKAS AND COLONOS

The town of Oventeni is located in the area called Gran Pajonal, a savannah traditionally occupied by the Ashéninkas. The Franciscans were the first to enter that area in 1734. By that year the Franciscans had seen their missions (and those of the Jesuits) destroyed by the Pano-speaking Shipibos. Franciscans were keen to enter an area that had been described to them as a land of pastures, where they could finally begin cattle ranching and permanent agricultural activities (Hvalkof 2003).

Nowadays, most community territory of the Gran Pajonal has been legally recognized (Hanne 2009). Oventeni remains a *colono* town with around 150 inhabitants (INEI and UNFPA 2007), surrounded by approximately 38 Ashéninka communities. The Health Center serves 2237 people and the medical team there was responsible for supervising the services provided at three Health Posts. Together the Health Center and the Health Posts serve a population of 3, 359 Ashéninkas (DIRESA-Ucayali 2010). The Health Center at Oventeni was staffed by six health workers: a medical doctor, a midwife, a nurse, and three nurse technicians (two were INTs). The doctor and the midwife were *serumistas* from Huancayo and Lima. Two nurse technicians understood the indigenous language, one of them – Imelda – was an Ashéninka INT who was from the Gran Pajonal and was fully bilingual.

1.9 HEALTHCARE SERVICES IN ATALAYA

The five fieldsites had two characteristics in common: (1) they had a health facility and (2) at least one INT working there for at least the last 6 months before my arrival. Overall, access to health services in Ucayali and Atalaya is poor given the distances most people have to travel to get to a health facility in a rural area. The three indigenous communities I stayed at were privileged because they all had a primary health care facility located in their territory. According to the PAHO, there should be one health facility per 1000 people; in Atalaya there are 26 health facilities for a population of 48,037 which means there is deficit of 24 health posts (MEF 2000).

Besides the limited number of health facilities in Atalaya, there is also a shortage of health professionals. In 2009, there were sixteen doctors, three dentists and thirteen nurses in Atalaya for a population of over 48,000. The bulk of health workers are nurse technicians working by themselves in a health post.

Currently in Atalaya, the range of population that the health posts serve varies greatly. Some health posts serve a population of 300 people, others up to 4000 people. Health Centers serve a larger population (about 10,000 people) given they have more health personnel (DIRESA-Ucayali 2010). In spite of the work of the health sector to reach out to the entire population, in 2010 24.3% of children under three years old were undernourished, despite that most health efforts are geared to reverting this trend (GRU 2011). As I was able to observe, the priorities for the health workers were to ensure children under five received all mandatory vaccinations, and children under five receive nutritional help through the national food program (PRONAA – *Programa Nacional de Ayuda Alimentaria*). Children's weight and height were carefully controlled every month and mothers were encouraged to bring children under five to

the health post for vaccinations. The food donations were a strategic way of making mothers come to the Health Post bringing their children for their vaccinations.

In Atalaya indigenous people receive healthcare at government health facilities. Government health facilities provide services within the framework of the *Seguro Integral de Salud* (SIS). The SIS is a national health insurance program created in 2001 to provide universal health coverage and is sponsored by the MoH. Its aim is to manage public funds so as to guarantee universal access to healthcare and to contribute to the improvement of people's health (SIS 2011). Its key beneficiaries are people who are too poor to be insured either privately or through the social security system.

In Peru, any person who wants to receive free services at a governmental health facility must be enrolled in the SIS. Depending on their income, some families might have to pay a small monthly sum to be enrolled in the SIS (SIS 2011). Given that Amazonian indigenous communities are classified as *Población Amazónica Dispersa* (Disperse Amazonian Population) Amazonian indigenous people do not have to go through an evaluation process to be covered for free by the SIS.

Under SIS, people are entitled to receive free medications to treat their ailment. It was common, however, for the health post to run out of medications. One of the reasons for the scarcity of medications was that health workers had to travel to the nearest town to pick up the monthly allocation of medications. In Atalaya, the government rarely allocates a budget for gasoline for the trip. In order to avoid paying for the gasoline out of their own pocket, health workers would delay their trips to go and pick up the medications. They would rather wait until someone from the community was coming from Atalaya or Bolognesi and ask the person to do them a favor and pick up the medications.

During my research, I visited two types of health facilities: Health Posts and Health Centers. A health post provides services not only for the community where it is located, but all the communities under its jurisdiction, as shown in Figure 4 . Health Posts are usually part of a bigger administrative unit called a Microrred. The Microrred is headed by a Health Center. Health Centers are better equipped to handle medical emergencies and conditions that require hospitalization since they have better infrastructure and a full medical team. A health center usually has a doctor, a nurse, a midwife and one or more nurse technicians. As we will see in Chapter 4, working alone in a Health Post or as part of a team in a Health Center had a great impact on INT practices and their use of an intercultural approach to health care. When they worked by themselves there was more freedom to implement intercultural health practices while, when working together with other health professionals they were under constant supervision of their work. As I will show In Chapter 4, if their colleagues disapproved of indigenous medicine, INT's efforts to combine both sets of medical practices had to be done out of sight.

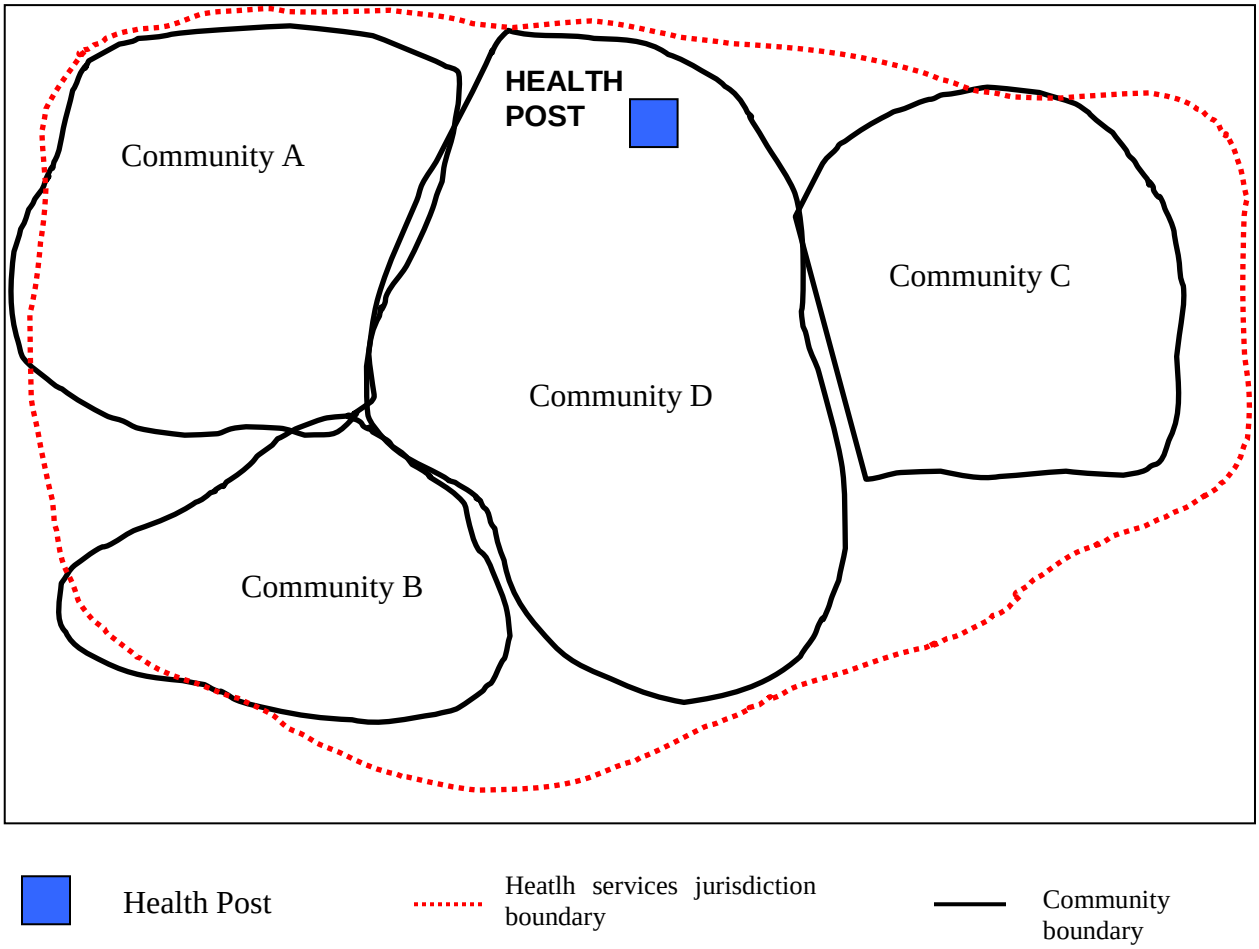

Figure 3. The health post and its jurisdiction

2.0 AIDESEP AND ITS APPROACH TO INTERCULTURAL HEALTH

In this chapter, I focus on the indigenous organization called AIDESEP. I use it as an example of the type of indigenous organizations that burgeoned in the Latin American region during the 1970s and 1980s, under the umbrella term "indigenous activism." Indigenous activism encourages the increased participation of indigenous people in Latin American politics. I will concentrate on AIDESEP's indigenous health program, the *Programa de Salud Indígena* (PSI). As we will see, the PSI's goals are tied to broader political discussions about the recognition of indigenous cultural practices, renegotiations between indigenous people and the State in Latin America, and the concept of interculturalidad. The concept of interculturalidad aims at developing a new model for fair intercultural relations that will promote justice and translate into policies and programs respectful of indigenous people's needs, demands and cultural characteristics.

In this chapter I also discuss the complexity of applying a concept like interculturalidad as the basis for policy decisions and concrete action, using the example of AIDESEP's indigenous health program. There are many obstacles to using a concept like interculturalidad to reduce inequalities and unequal power relations between different cultural groups within a society (Olivé 2009). I will discuss how indigenous organizations use the term "interculturalidad" to frame their demands and projects and I compare and contrast this with the different ways the different levels of government use it. This will set the basis for further

discussions on intercultural health and the different requirements indigenous people and the State have for such a project.

2.1 AIDESEP AND INDIGENOUS ACTIVISM

AIDESEP is a coalition of indigenous organizations representing sixty-four ethnic groups from the Peruvian Amazon and 1,340 indigenous communities organized under forty-eight indigenous federations (Inoach Shawit and Reategui Silva 2003). AIDESEP was created in the 1980s. By that time, several indigenous federations throughout the Peruvian Amazon had been challenging state policies that promoted the "colonization" of the Peruvian Amazon for at least a decade. The State was encouraging poor migrants from the Andean region to invest in agriculture and other natural resources in the Peruvian Amazon. The government also gave incentives to companies interested in exploiting natural resources located in indigenous territories.

Indigenous organizations used the "*Ley de Comunidades Nativas*" (Native Communities Law) to their advantage. The law was issued in 1974 by the military government and allowed indigenous Amazonian communities to receive communal property titles over their territories (Inoach Shawit and Reategui Silva 2003). The *Ley de Comuniades Nativas* came at a time when indigenous people were already aware their territories were being sold or leased to private and state enterprises and/or to people from the Andean region now known as "*colonos*" (colonizers). Supported by the *Ley de Comuniades Nativas*, indigenous federations responded to the encroachment and loss of land. They first responded independently to these colonization

processes; and later grouped themselves into larger federations along ethnic and geographic lines (Meentzen 2007).

In 1979, indigenous federations from the Peruvian Amazon joined forces to form the *Coordinadora de Comunidades Nativas de la Selva Peruana* (COCONASEP). COCONASEP changed its name the following year to AIDESEP, an umbrella organization representing all indigenous organizations from the Amazon (Inoach Shawit and Reategui Silva 2003). AIDESEP was born in response to the need for a coherent, articulated response to State-driven policies that violated indigenous peoples' rights, such as their right to common property, common-law within their territories, and language rights. For example, indigenous organizations fought the imposition of the Spanish language throughout the public school system by demanding for the allocation of bilingual teachers in public schools located in indigenous communities.

AIDESEP and other indigenous organizations know that indigenous territories are central to the wellbeing and protection of indigenous people. In fact, Convention 169 of the International Labor Organization (ILO) on the rights of indigenous and tribal people has an entire section pertaining to the role of National Governments in protecting indigenous territories (ILO 1989). The forest ("*monte*") is where indigenous people obtain their food and the medicinal plants they use to heal themselves, as well as the materials they use to build a boat or shelter, and the water they consume. For indigenous organizations of the Peruvian Amazon, defending their territories against trespassing is crucial to protect future generations (Scurrah 2008). Territorial protection has become an axis of AIDESEP's political goals.

In Peru, AIDESEP was not the only organization seeking to represent indigenous organizations from the Amazon. For example, there was also the *Confederación de Nacionalidades Amazónicas del Perú* (CONAP). Both AIDESEP and CONAP emphasized

recognition of their indigenous identity and their cultural rights as the reason for organizing (Meentzen 2007). Once AIDESEP achieved legal recognition in 1985, it defined its goals as follows: "[to] defend indigenous territories, natural resources, indigenous culture, indigenous languages and the human and political rights of indigenous peoples"[37](Inoach Shawit and Reategui Silva 2003:17).

AIDESEP is an example of the various indigenous organizations throughout Latin America that emerged during the 1970s and 1980s and whose goals revolved around the protection of indigenous territories, ethnic identity and cultural recognition. Before the 1970s, Albó (1991) explains, indigenous people rarely participated in politics except in the roles of migrants, peasants, rural laborers or casual urban workers. It was in the 1970s and 1980s that indigenous people became political actors in their own right. As Yashar (2005) explains, "it is not that Indians have not organized in the past. However, they have not organized along ethnic lines to promote an explicitly indigenous agenda" (pg.5).

Several factors enabled the surge of indigenous activism in Latin America. International organizations played a role in the emergence of indigenous issues in international debates through the implementation of numerous indigenous peoples' initiatives (Sieder 2002; Stavenhagen 2002). International declarations on human rights, ecological protections, decolonization, and cultural entitlements also facilitated the emergence of politically active indigenous groups in Latin America (De la Peña 2005). Finally, the transition from authoritarian rule across the continent resonated with indigenous peoples claims and helped to solidify human

[37] [La Asociación Inerétnica de Desarrollo de la Selva Peruana; es la organización nacional de los pueblos indígenas amazónicos] cuya finalidades luchar por la defensa del territorio, los recursos naturales, la cultura, el idioma y los demás derechos humanos y políticos de los pueblos indígenas." (p.17)

rights discourses and enabled the upsurge in ethnic organizing and indigenous protagonism (Sieder 2002).

As in the case of AIDESEP, indigenous peoples' major demands were first centered around the recognition of territorial based issues such as struggles over land and resources as well as local issues, such as the contamination of rivers or lack of bilingual schools (Hutchins and Wilson 2010). Later the struggle over such concrete problems led to more complex issues, intimately tied to cultural rights and ethnic identity, and the recognition of indigenous rights became the fundamental basis of the indigenous movement and its relationship to the State (Pareja 2008; Hutchins and Wilson 2010).

In Bolivia, Peru, and Ecuador indigenous organizations began to ask for "separate rights along with their own identity and history, prompting the breakdown of the modernizing movement and the revaluation of ethnicity as an element of political participation" (Pareja 2008:816). De la Cadena (2006) points out that organizations began using words such as pluriethnic, pluricultural, and plurinational, which "reflected their demands for respect of their ethnic singularities" (p.215). The strengthening of indigenous organizations in the region represented a major change in the relationship between national states and indigenous people in Latin America, where indigenous movements "took off" and began to gain visibility as social and political actors (Becker 1995; Brysk 1996; Sieder 2002; Albo 2005; Jackson and Warren 2005; Bowen 2007).

Jackson and Warren (2005) refer to indigenous social movements as an expression of "ethnic activism" given that most of their demands are grounded on ethnic and cultural claims. Other authors (Hale 1997; Garcia 2005) use the term "identity politics" given that ethnic identity is at the center of their demands. In any case, citizenship, or rather indigenous citizenship

became the central concept used by social movements demanding "new spaces for a dignified, differentiated participation as citizens in their national societies" (De la Peña 2005:732). For Yashar (2005), "the contemporary formation of indigenous movements in Latin America reflected that indigenous people were contesting the terms of citizenship" (pg.6).

The term indigenous citizenship implies the need for acknowledging indigenous peoples as citizens of the nation-states they live in; it focuses on their demands for equal rights like all citizens of those countries while getting recognition of special rights as indigenous peoples (Yashar 2005). Indigenous movements are "opening the debate of what citizenship entails, particularly in a multicultural context" (Yashar 2005:5) The concept of indigenous citizenship emphasizes equality as citizens before the law while simultaneously demands that cultural specificities be recognized. Being citizens –indigenous citizens– enables them to demand distinct rights for themselves (Leyva solano 2005). For Garcia (2005), becoming an indigenous citizen can be seen as a dialectical move to:

> synthesize the (colonial) recognition of ethnic difference and the (populist) policies of national inclusion, but without the hierarchies that both implied. Additionally, indigenous citizenship stands not for what states give to subjects but for the agency and autonomy that indigenous people claim to construct it for themselves (p.4)

The concept of indigenous citizenship is directly related to efforts to establish a new type of relationship with the State. As Miller (2006) explains, indigenous movements in Latin America challenged the idea of national community:

> Indigenous movements in Ecuador, Mexico, Guatemala, Bolivia and elsewhere (…) began to challenge the authority of the central state and its claim to be coterminous with the national community. (…) [S]uch movements mostly wanted to renegotiate, rather than reject, a role in the existing nation-states (p.203).

As part of indigenous peoples efforts to negotiate with the State, indigenous leaders began to demand "greater and improved attention to their cultures and languages, and

strategically regarded the indigenous culture as a political resource in order to gain more visibility and participation in the countries they lived in" (López 2009). It is precisely these ideas that Miller (2006) refers to when he notes that indigenous movements "wanted to renegotiate, rather than reject, a role in the existing nation-state" (p.203) Miller implies that indigenous movements wanted to renegotiate their way of belonging to a particular Latin American nation. It is in this context that the concept of *interculturalidad* - as it is used by indigenous organizations - becomes useful to frame indigenous social demands.

In as much as indigenous organizations want to be part of the Nation State, but also have their distinctiveness acknowledged, interculturalidad is a relevant concept because it does not imply the separation of policies from the State. Interculturalidad highlights the need to create a space for indigenous people to participate in the way policies are conceived. Applying an intercultural approach to any given State policy reverts the historic trend of marginalizing indigenous organizations from the policy-making process.

As we will see in detail in the following subsection, through its Indigenous Health Program ADIESEP is advocating the implementation of intercultural health policies that recognize the value of indigenous medicine at state-run health facilities. A national, standardized monocultural health policy ignores the cultural characteristics of indigenous peoples and does not recognize –or even worse– dissuades the use of indigenous medical practices. AIDESEP's PSI is an example of an indigenous organization trying to make inroads into health policy.

2.2 AIDESEP'S PROGRAMA DE SALUD INDÍGENA (PSI)

In 1991, AIDESEP created the PSI whose main goal –at the time– was to strengthen indigenous health systems. Juan Reátegui was the first director of the PSI. Juan belongs to both the Shawi and the Awajún indigenous groups (his mother is Shawi and his father is Awajún) and his parents were both recognized indigenous healers (*Waymacos*) in their respective communities (Reategui Silva 2003). Upon completing his secondary education, Juan received a scholarship to study Nursing at the Universidad Mayor de San Marcos. He remained active in AIDESEP activities while a student and in 1989 upon graduating from the university; had the opportunity to travel throughout the Amazon to design a health project for AIDESEP.

During his first visit to indigenous communities as a university graduate, Juan Reátegui realized that governmental health services were not effectively reaching people living in indigenous communities. He also noted that indigenous health systems had become weak over the years, and felt that AIDESEP as an indigenous organization had to do something about it. During an interview in 2000, Reátegui stated that despite the problems in indigenous communities in the early 1990s, there were also opportunities for change:

> *"There were many problems, but at the same time I found something very special, very important that became the foundation of a future initiative: all communities, all mothers, all shamans and vaporadoras [women who use vapor to heal], used medicinal plants, and I thought it was a good idea to begin from that reality" (Reategui Silva 2003)*[38]

In 1991, Juan was elected to AIDESEP's *Consejo Directivo* (National Council) and in 1992 created the PSI. The PSI first aimed to rescue indigenous knowledge about health and

[38] "Habían muchos problemas, pero al mismo tiempo encontré algo muy singular, muy importante, de lo cual nació una iniciativa: que todas las comunidades, las mamás los curanderos y vaporadores que había identificado, todos utilizaban sus plantas medicinales y pensé que sería mejor empezar por allí." (p.99)

further support indigenous health systems (Inoach Shawit and Reategui Silva 2003). In an article written by Juan Reátegui and Gil Inoach (who was president of AIDESEP for two consecutive periods, between 1996 and 2002), the authors explain what they mean by the term "indigenous health systems" (*sistemas de salud indígena*). The term refers to: medical human resources and the materials used for healing, such as plants, songs (called *ícaros*) or some musical instruments, as well as the spiritual and magical aspects of indigenous medicine (Inoach Shawit and Reategui Silva 2003).

When Juan Reátegui promoted the creation of the PSI he knew there was a great deal of assimilation pressure on indigenous knowledge systems:

> "*the need to recover all the knowledge, technologies, information (…) I thought it was sad to see the indigenous world assimilated, living side by side a culture that is not theirs. What I wanted was to articulate [indigenous medical knowledge] recover it, strengthen it and develop it. And that is what we did as part of my role in the Indigenous Health Program*" (Reátegui, interview 2008)[39]

The PSI managed to secure funding from a government agency called FONCODES (*Fondo de Cooperación para el Desarrollo Social*), which supported small-scale projects promoting social development. The PSI began its activities in the Province of Atalaya through field visits to indigenous communities oriented at "recovering shamanic practices" (*Recuperar el recurso Chamánico*) (Reategui Silva 2003:99).

During the visits, Juan and his team would talk with indigenous medical specialists and indigenous people from the communities to promote the recovery of indigenous medical

[39] "Vi la necesidad de recuperar esa sabidurías, esas tecnologías, esos conocimientos y tratar de que eso –que yo lo veía como un sistema propio que tenían ellos -. Sin embargo (este sistema) ha sido desconocido por la cultura occidental, por la misma educación, por la misma salud o muy poco se valoraba eso (…) Entonces era triste de que el mundo indígena sea asimilado, conviva con una cultura que no es suya. Entonces lo que yo quería era articular lo suyo, recuperarlo, fortalecerlo y desarrollarlo. Y eso es lo que hemos hecho como el propósito de mi participación allí (en el PSI)."

traditions (Reategui Silva 2003). In many instances, Juan's team had to convince people in the indigenous communities that the progressive loss of indigenous medical practices was a problem. Many saw little need for recovering indigenous medical traditions. As Juan explained: "*Among other things, there was not even the recognition of this valuable community resource [*indigenous medical specialists*], they [*people who lived in the communities*] did not know who they were*[40]" (Reategui Silva 2003). Thus, although Juan, an educated indigenous leader, valued indigenous medical traditions and was concerned for the lack of importance people assigned to them, he could not find a similar preoccupation among people in indigenous communities or among governmental health authorities (Reategui 2008). The situation Juan encountered in Atalaya at the beginning of his term as director of the PSI was repeated in the other communities he visited throughout the Peruvian Amazon.

Juan Reátegui strongly believed that it was vital for the indigenous movement to support the recovery of indigenous medical traditions and show people in the communities and the government the importance of indigenous medical specialists. The creation of the PSI responded not only to his particular concern regarding indigenous medical practices, but also to the poor health conditions of indigenous people and the need to design a strategy to address this problem. In the Book "*Sueños Amazónicos*" Reátegui explains that the creation of the PSI responded – among other reasons – to the negative experience of indigenous peoples at health services provided by the Peruvian Ministry of Health, and to the increased frequency of epidemics brought in by outsiders (Reategui Silva 2003p.178). Reátegui remembered the high mortality rates in indigenous communities during the cholera epidemic in the 1990s. The State was slow to respond to the epidemic (Reategui Silva 2003).

[40] "Entre otras cosas, ni siquiera se reconocía este recurso tan valioso para la comunidad: no se le conocía." (p.99)

However, Reátegui also recognized that the organization of indigenous peoples from the Amazon was gaining strength and that a number of organizations were making claims around cultural revaluation. This provided an opportunity to create the PSI and to advocate for the rescue of indigenous medical practices[41] (Reategui Silva 2003). The PSI's official goal is to "Raise living standards through strengthening and developing the intercultural approach of indigenous health systems, according to the cultural particularity of each indigenous Amazonian group[42]"(AIDESEP 2007).

More than two decades have passed since the creation of the PSI, but its two lines of action have remained: the revalorization of indigenous medical systems (both among indigenous people themselves and among government officials) and advocacy for changes in the health services provided to indigenous people by the national government [43](AIDESEP 2007). Juan Reátegui explains how the PSI aim was to preserve knowledge and improve the health of people in indigenous communities:

> "[The Programa de] Salud Indígena is a political and strategic proposal from within the organization of the indigenous peoples of the Peruvian Amazon to preserve and improve the health of its people. It has two components: the first, fundamental component is to reassess and develop indigenous health systems as a central part of the structure of indigenous society. The second, in the context of *interculturalidad* is to seek complementary spaces with modern Western [medical] systems to ensure a better health care for indigenous peoples (…) [and] to enable the concurrence of different worldviews, each contributing from its own reality [44]" (Reategui Silva 2003).

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[41](1) Por la experiencia negativa de los pueblos indígenas con la atención de salud dada por el Ministerio de Salud (a a través de su gestión). (2) Por la presencia cada vez más frecuente de epidemias producidas por enfermedades introducidas desde occidente (…) (3) Por la tendencia cada vez más fuerte de las políticas indígenas de la cuenca amazónica, hacia la revalorización cultural."

[42] Elevar el nivel de vida fortaleciendo y desarrollando el enfoque intercultural de los sistemas indígenas de salud, de acuerdo con la particularidad cultural de cada pueblo indígena amazónico.

[43]"En lo sustancial plantea la revalorización de la cultura sanitaria de los pueblos indígenas amazónicos y una reestructuración de la demanda de salud hacia el gobierno nacional."

[44] "[El Programa de] Salud Indígena es una propuesta política y estratégica desde dentro de la organización de los pueblos indígenas de la Amazonía peruana para preservar y mejorar la salud de los pueblos. Tiene dos componentes: el primero y fundamental es revalorar y desarrollar los sistemas de salud indígena como parte central de la estructura de la sociedad indígena. El segundo, en el marco de la interculturalidad es buscar espacios de complementariedad en todos los campos con los sistemas occidentales o modernos de salud que garanticen un mejor nivel de atención a la

For the PSI, an intercultural approach finds ways to articulate Western and indigenous medical knowledge to improve health care for indigenous people. The term intercultural health for AIDESEP's PSI refers to the idea of using both medical traditions to improve the quality of services received by indigenous people (AIDESEP 2007; Reategui Silva 2008). The PSI stresses the inadequacy of current Western-based state health services and the importance of rescuing indigenous medicine which is a basic component of "indigenous culture, people's well-being and indigenous identity" (AIDESEP 2007). The following sections describe the different efforts promoted by the PSI to use indigenous medicine and promote an intercultural approach in order to meet its goals and engage with the Peruvian State to improve health services for indigenous people.

2.2.1 ENGAGING THE PERUVIAN STATE TO DELIVER INTERCULTURAL HEALTH SERVICES

Juan Reátegui ended his term as an official AIDESEP leader in 1994 but remained the director of the PSI until 2010. One of the first steps taken by the PSI was to seek governmental support to conduct a survey of existing indigenous medical specialists and their medical knowledge (Reategui 2008, interview). In 1992 the PSI managed to secure funding from an international organization that supported a project to identify and create a record of existing medical specialists in three areas of the Peruvian Amazon: Madre de Dios, Ucayali and San Lorenzo (Hvalkof 2003). This survey showed that health care in the communities varied depending on whether there was a geographically accessible health facility.

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salud de los pueblos indígenas e incluso de la población peruana en conjunto al posibilitar la concurrencia de cosmovisiones distintas, pero cada una aportadora desde su propia realidad."

In several communities there were no health facilities and health care was exclusively provided by indigenous healers: *parteras* (traditional midwives), *sheripiaris* (indigenous healers), *hierberos* (specialists in herbal treatments), and *vaporadoras* (Reategui 2008-interview). Despite the diversity of indigenous healers, the health of local people was poor and the PSI realized that it was necessary to begin negotiations with governmental health authorities in order to improve this situation for indigenous communities. AIDESEP's leaders argued that indigenous people, like any other Peruvian citizens, were entitled to receive free governmental health services (Reategui 2008, interview).

A source of concern for the PSI was the realization that in those indigenous communities which had regular access to Western medical care for several years, there was limited use of indigenous medical traditions (Reategui 2008, interview). As stated earlier in this chapter, the PSI wanted to reverse this trend so that medical traditions were not lost. At the same time the PSI project wanted to ensure the availability of government facilities and adequate Western health care. Juan Reátegui feared that the exclusive availability of Western services would eventually lead to a complete assimilation of people's medical choices towards Western medical services (Reategui 2008, interview). One solution from the PSI's perspective was to promote the delivery of intercultural health services open to indigenous medical traditions. This would not only acknowledge the existence of indigenous medical experts, but also promote their practice. There is no AIDESEP document describing exactly what this type of intercultural service would look like, or who would be providing such services.

The PSI's position vis-à-vis health service is that there should be more government-led intercultural health efforts where indigenous medical systems are not seen as being at odds with biomedicine (AIDESEP 2007; 2008). Despite considering indigenous medical systems as

essential for addressing the health needs of indigenous communities, the PSI has always been aware that no single health system would be able to solve all the health needs of the population (Reategui Silva 2003). That is why the support from the MoH is essential for the delivery of intercultural health services, yet obtaining that support has been a complicated process. Among other things, Western medicine is the paradigm of all governmental health interventions in Peru and "accommodating" other medical traditions is at best "odd" for medical practitioners exclusively educated in Western medicine.

For Juan Reátegui, the problem with governmental social policies is that when they are implemented in indigenous territories they end up being an imposition of Western over indigenous ways (Reategui 2008, interview). This is particularly evident when it comes to health policies. For instance, health workers assigned to provide services in indigenous communities are ignorant of indigenous medical practices and they base their care exclusively on Western medicine, which is considered the "right" way to provide health services and better than indigenous medical systems (Reategui 2008). From Juan's perspective, the national health system is ill-prepared to respond to the specific health needs of indigenous people:

> "*the national health system responds [to the health problems in indigenous communities] with isolated and sporadic vaccination campaigns, poorly equipped health posts, badly paid nurse technicians who rarely do their work, unpaid community health promoters, incomplete supplies, inadequate and irregular drug supplies; insufficient staff and budget allocations given the size of the challenges; absence of reliable statistics and burdensome bureaucratic processes that makes adequate response even more difficult. (…)* ***What we are saying is not only that medications should reach (indigenous communities…) if the structure that is there is not adequate and appropriate for the culture of indigenous people***" (Reategui 2005, emphasis added)[45]

[45] "Frente a lo anterior, el sistema nacional de salud responde con vacunaciones aisladas y esporádicas; postas pobremente equipadas; técnicos sanitarios mal pagados que, como tal, rara vez cumplen con su labor; promotores de salud de las propias comunidades que tampoco son remunerados; dotaciones mayormente incompletas, inapropiadas e irregulares de medicamentos; asignaciones de personal y presupuesto insuficientes para la dimensión de los problemas encontrados; ausencia de estadísticas confiables y presencia de trámites burocráticos oficiales que terminan de entorpecer los niveles mínimos subsistentes de capacidad de respuesta a los desafíos presentados por el sector salud en la región, entre otros. (…)Entonces lo que estamos diciendo nosotros es que no sólo lleguen las

For Reátegui, it is imperative that the state develop an intercultural approach. Such an approach should – among other things – enable the combination of both medical knowledges (2008, interview). However, as much as interculturalidad might seem a harmonious solution for improving health services, in the medical arena it is not easy to change the way the medical establishment perceives indigenous medical practices. For Lacaze (2002), one of the key problems with designing and implementing intercultural programs is that "interculturalidad presupposes the recognition of the validity of other modes of knowledge and action than those developed in the West". Furthermore, interculturalidad also entails a need to develop "new strategies that can then build on the capacity of indigenous peoples to take a more active role in the conception, design, management and control of local health systems."(p.167)[46] In a context such as Peru, where indigenous people are in many cases still considered "primitive," official recognition of indigenous medical practices and more active participation in health services appears to still be an unattainable goal.

2.2.2 INTERCULTURAL HEALTH AND INDIGENOUS KNOWLEDGE

The recognition of the validity of indigenous medical systems is the first step towards imagining a health system that combines both sets of medical knowledges as equal and indigenous advocacy plays an important role in promoting recognition of indigenous medical systems. Ruiz (2006) reviewed examples of Latin American indigenous organizations'

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medicinas, las postas, las herramientas para atender a la gente si este establecimiento… si la estructura misma que está allí no es adecuado y pertinente con la cultural de los pueblos indígenas."

[46] Lacaze explains that "Si la interculturalidad presupone el reconocimiento de la validez de otros modos de conocimiento y acción que los occidentales, las nuevas estrategias pueden entonces construirse sobre la capacidad propia de los pueblos indígenas para asumir un papel más activo en la concepción, el diseño, la gestión y el control de los sistemas locales de salud." (p. 167)

arguments surrounding intercultural health and came to the conclusion that the revindication of the effectiveness of indigenous medical systems has become part of their broader political struggles to protect and promote their cultural heritage. In Bolivia and Peru for instance, indigenous organizations stress the discrimination their medical systems have been subject to for centuries in favor of biomedicine (Johnson 2010). Furthermore, in the Peruvian case, exclusive governmental support to biomedicine has affected the maintenance and development of indigenous medical systems, and it has undermined its continuity for future generations (Bird 2002).

From the state's perspective and in the context of indigenous activism, intercultural social policies became a way of recognizing indigenous citizenship in Latin America (Park 2006). According to Latin American scholars writing about interculturalidad (Tubino 2005), beginning in the 1990s, the term "interculturalidad" refers to the search for respectful ways to deal with cultural differences between indigenous people and non-indigenous people at different levels: everyday interactions, public policies, government offices. For Tubino (2002) the greatest challenge for interculturalidad is the need to confront former social hierarchies and produce a democratic state that does not make the renunciation of indigenous culture a condition for citizenship. In order for this to happen, changes have to occur not only within the State, but also in the society as a whole. There is a difference, however, between theoretical discussions about "interculturalidad" and discussions about applied intercultural social policies.

At the theoretical level, interculturalidad describes an ambitious, ideal situation. For example, Tubino (2005) states that interculturalidad is an ethical and political project that proposes respectful dialogue between different cultural groups, enabling constructive changes in

both groups (Tubino 2005). He points out that "interculturalidad is an important topic at the discursive level, but not at the level of the state's actions"[47] (p.84).

Viaña's (2010) view of interculturalidad goes beyond a dialogue between cultural groups and proposes that interculturalidad is – or ought to be – a more subversive project which aims at challenging the historical conditions that have maintained indigenous people in a subaltern social, political and economic position. This is what Walsh (2009) and Tubino (2005) call *Interculturalidad Crítica* (Critical Interculturality) which questions discrimination towards certain cultural practices and the persistence of a hegemonic cultural system over indigenous cultural systems (Walsh 2009:9). In contrast with Critical Interculturality, Tubino and Walsh propose *Interculturalidad Funcional* (Functional Interculturality) to describe State-promoted intercultural approaches. Functional Interculturality promotes the recognition of cultural diversity and inclusion both within society and the nation-state, yet leaves aside those more abstract or embedded patterns of institutional and structural power that maintain inequality (Tubino 2005; Walsh 2010).

Although such definitions are useful for thinking about how interculturalidad is applied differently depending on the agency or organization, the limitation of such definitions of interculturalidad is they fail to explain how to apply an intercultural approach to a particular program or policy. For instance, Walsh (2009) argues that while Functional Interculturality is used by the State to promote the inclusion of indigenous people without promoting larger changes in the State's relation with indigenous people, Critical Interculturality is built on the premise that indigenous people have suffered a long history of submission and thus aims at deeper societal and political changes. However, these interesting distinctions still do not provide

[47] [La interculturalidad] es un tema importante en el plano discursivo pero no en el de la acción estatal (Tubino 2005: p.84)

a set of instructions or a roadmap for how to apply the concept of interculturalidad in concrete situations, or how indigenous organizations can avoid falling into the "trap" of attaining functional changes but not critical ones such as having bilingual teachers but not advocating for changes in the contents of the school curricula incorporating the history of local indigenous groups.

Another classification of interculturalidad has been proposed by Xavier Albó (2002). Albó argues there are two different levels at which interculturalidad functions: the micro and the macro levels. Micro interculturalidad, Albó (2002) explains, is what happens at the level of interpersonal relations, while macro interculturalidad aims at changes at the level of social and symbolic structures. This classification might be more useful than the one proposed by Walsh and Tubino. For instance, if we apply this classification to current intercultural efforts in the health sector, we will see that a macro interculturalidad implies changing the way the health system functions and the way health policies are designed to take into account indigenous peoples health needs and cultural characteristics. Such macro-level changes will have to translate into health workers actually enabling and allowing the use of indigenous medical practices at the health facility. AIDESEP, with its training project for indigenous youth, is attempting to achieve this goal. I will provide a detailed description of that project in the following section.

If we take AIDESEP's efforts to ensure indigenous communities receive intercultural health services as an example, we will see that for AIDESEP, the implementation of an intercultural health approach ought to translate into changes in the way the government provides health services to indigenous peoples throughout the Peruvian Amazon. Such changes are based on respect for indigenous medical practices with the goal of delivering care that is more appropriate to the health needs and cultural characteristics of indigenous people. Intercultural

Health for AIDESEP also implies promoting structural conditions for a dialogue between the two medical systems. However, as we will see in Chapter 4, AIDESEP's strategy to make structural changes in the health system is far from being achieved by INTs who are successfully using an intercultural approach where they work but not having opportunities to advocate for policy changes and increase the recognition of indigenous medical practices.

The PSI does not question biomedicine's efficacy or ability to save lives, but it does question biomedicine's capacity to open up spaces for the recognition of indigenous medical systems. Medical anthropologists use the term biomedical hegemony to refer to –among other issues– the preeminence of biomedicine over other medical systems. Biomedicine's hegemonic position is a result of historical, economic and social processes that have enabled it to become the gold-standard for most health interventions throughout the world. As a hegemonic system, it is the medical system accepted by most people in the society as the only valid approach to illness (Csordas 1988).

Anthropologists have long emphasized that the production of knowledge is always a product of historical contexts, in turn imbued with aspects of power, authority and legitimation (Pottier 2003; Briggs 2005)[48]. For Buchillet (1991) the representations of indigenous medicine in Brazil (which are applicable to other countries) have been for many years seen as exotic objects of study that lacked coherence and efficacy to solve health problems. Indigenous medicine, she explains, was seen as a characteristic of underdeveloped societies and cultures that were destined

[48] Authors like Quijano (2000) argue that in the post-independence era Europe maintained its hegemony over the new model of global power. Europe had managed to successfully concentrate "the control of subjectivity, culture and especially knowledge and the production of knowledge under its hegemony." He explains that during colonial times Europeans: "repressed as much as possible the colonized forms of knowledge production, the models of the production of meaning, their symbolic universe, the model of expression and of objectification and subjectivity." In Latin America, the repression in the field of meaning production and knowledge production was most violent, profound, and long lasting among the indigenous people, "who were condemned to be an illiterate peasant subculture stripped of their objectified intellectual legacy."

to disappear as Western medicine advanced and demonstrated its capacity (Buchillet 1991). As Zhan (2001) argues, what counts as science (or medicine), is still inextricable from the *who* is authorized to define and craft science and rationality.

The advancement of biomedicine at the expense of local medical traditions is not particular to the Peruvian case. Various authors have pointed out that in medically plural environments - where biomedicine is one of the available systems - the relationship between biomedicine and indigenous medical systems reflects the hierarchical relations existing between Western culture and indigenous culture (MacLeod 1988; Hall 1996; Baer, Singer et al. 1997). Indigenous people's inferior social position has often led to a rejection of their cultural practices, which have been downplayed as "backward" and therefore ignored or fought against (Bastien 1992).

Nineteenth-century colonialism of Asia and Africa is one of the historic periods that enabled biomedicine to become hegemonic. Scholars of colonial medicine argue that the expansion of Western medicine was one of the various avenues through which Western culture was imposed on the colonies (Packard 1997; Briggs 2005). Its efficacy to stop epidemics and to prevent diseases was a demonstration of its power and superiority vis-à-vis local healing traditions. There was no recognition that several European medical "discoveries" had originated in other parts of the world, like the use of quinine to prevent malaria (Reategui 2005). Furthermore, it appears that many ignored that "Western medicine, like virtually all other things European, received official support while traditional systems either received none or were consciously suppressed" (Gish 1979:6). Biomedicine during and after colonialism came to supersede traditional medical systems in prestige and influence (Baer 2004).

Just as Juan Reátegui explains in reference to the Peruvian Amazon, in other countries indigenous medical practitioners were actively ignored by the government. In Bolivia for example, Bastien (1992) found that government officials, doctors and pharmacists thought health projects should do away with *curanderos*, shamans, midwives and herbalists. Green (1994) recounted how after independence in 1975, the government of Mozambique discouraged and sometimes suppressed traditional healers who were regarded -together with other traditional practices- as "purveyors of obscurantism", and jeopardized the nation's effort to modernize (p.6). Oftentimes, ideas about development and modernization justified the "attack" on indigenous medical practices (Piazza and Lima de Juarez 2003). Traditional medical practices came to be perceived by new nation-states during the 1970s as a result of the independence of the ex-colonies in Africa as obstacles to the country's development and thus, responsible for reducing the possibilities of achieving the health goals imposed by international aid agencies.

In certain cases, the opposite happened and indigenous medical traditions were portrayed as the "essence" of national identity. Traditional healers in Zaire received unconditional government support from the nationalist regime during the 1970s (Bibeau 1991). According to Frankenberg (1980), in both Zambia and India, part of the populist anti-imperialist rhetoric was: "if not opposition to Western medicine, at least support for traditional healers and systems of medical thought" (p.198). Paradigms and perceptions of indigenous medical systems have changed over the years and new paradigms have evolved. This includes contemporary discourses on *interculturalidad* used by Latin American governments to describe their new openness towards cultural diversity and indigenous people, as well as by indigenous social movements, which frame their demands in terms of cultural recognition. However, accomplishing intercultural health services goes beyond the realm of ideas and into the realm of concrete

practices and guidelines that ought to be changed. One guideline that needs to be changed is the criterion used to select and train health personnel assigned to work at governmental health posts in indigenous communities.

Building bridges between indigenous people's demands and health services is a difficult task given the State's limited resources. One expression of such limitations is the lack of adequately prepared personnel assigned to work in indigenous communities. Throughout the Peruvian Amazon, indigenous people receive healthcare mainly from health workers at government health facilities. Health workers are non-indigenous (*mestizo*) professionals exclusively trained in biomedicine, such as doctors, nurses, midwives or nurse technicians. In many communities – such as the ones I visited – indigenous healers are no longer the most important source of care. However, other studies show that although Amazonian indigenous medical knowledge and practices have been discouraged historically, indigenous medical specialists continue to play an important role in the provision of healthcare in their communities (Burga Cabrera 2005). In both cases (whether indigenous healers continue to play an important role in the communities' health or not) there is usually little interaction between the two medical systems and its specialists (we will see in the following chapter this is one characteristic of intercultural health services).

AIDESEPs indigenous leaders believe the MoH lacks the flexibility required to address indigenous health needs (Reategui 2008, interview). The often-quoted example of allowing indigenous women to give birth according to their own cultural traditions within a health facility is, for Juan Reátegui, a misrepresentation of an intercultural approach. Even the official name "*adecuación cultural*" (cultural adaptation), implies that the health services are adapting to indigenous people's ways (in a rather condescending way) in one very specific "health issue"

rather than jointly building (together with the local population) ways to use indigenous medical principles side-by-side with Western medicine for a better outcome. Reátegui explained to me his disappointment with the MoH's approach to interculturalidad:

> "*What does "adecuación cultural" mean? It simply means that they want to put a band-aid [by saying] "Let's talk about interculturalidad." As a discourse, they talk about it in very emotional ways of course ... but that intercultural discourse is not being translated into State policy. (…).* ***So what we are saying is that [improving health services] is not only about providing medicines, building health posts, or giving health workers the tools to interact with [indigenous] people. [It is not intercultural] if the [health] facility... if the structure in place is not adequate and relevant to indigenous people's culture.*** *(…) The food health workers eat, the food they suggest people to eat is not what people think they should eat to heal, the medicinal plants that are required for the treatment are not available in the [health] facility. The land, the forest [people are used to, is not there] A health post, the health center is in an urban area. (…) There is a total divergence in both ideas (indigenous people's perception of interculturalidad and the State's). We consider that an intercultural health facility should be articulated with their territory, their forest, with culture, with their own status as human beings, in relation to the family ... then the food is adequate, balanced. Then the whole Western approach to the intercultural approach is out of place*"[49] (Reategui 2008, interview, emphasis added).

For Reátegui, despite the State's rhetoric towards indigenous people as one of "inclusion, interculturality, respect, and democracy", social policies do not reflect these principles (Reategui 2008, interview). For AIDESEP, the MoH's intercultural health efforts are not profound, nor concrete enough to have any visible outcomes. AIDESEP's definition of what intercultural health services look like, and what is required in order to determine whether a particular health

[49] Entonces adecuación cultural qué quiere decir, simplemente lo que quieren hacer es un poco poner un parche… "vamos a hablar de interculturalidad" de manera de discurso, hablan emocionados por supuesto… pero de ese discurso intercultural no se plasma como política de estado. (…). Entonces lo que estamos diciendo nosotros es que no sólo lleguen las medicinas, las postas, las herramientas para atender a la gente si este establecimiento… si la estructura misma que está allí no es adecuado y pertinente con la cultura de los pueblos indígenas. Para dar el parto por ejemplo, que sólo está el enfermo, y el indígena está la familia y no el enfermo solamente. La comida que comen, no está adecuado como él quisiera comer para curarse, las plantas medicinales que se deben de usar para el tratamiento no existe en el establecimiento. El territorio, su bosque y una posta, un centro está en una zona urbana. (…) Entonces hay una total divergencia entre dos posiciones. Hay un desfase obviamente. Consideramos que el establecimiento de salud intercultural debe estar articulado con su territorio, su bosque con la cultura, con su propio status de vida como seres humanos, en relación con la familia… entonces la alimentación es muy adecuada, equilibrada por cierto. Entonces todo este asunto desde el enfoque occidental la que mira el enfoque intercultural no tiene nada que ver.

facility indeed provides intercultural health care, is different from the one proposed by the Peruvian MoH[50].

Differences between grassroots and governmental use of interculturalidad has been highlighted by various authors (Tubino 2005; Walsh 2008). From the State's perspective, interculturalidad refers to a socio political strategy that aims to include cultural diversity in State institutions, setting the basis for positive, constructive relationships between the State and the different cultural groups in society (Ruiz 2006). State sponsored interculturalidad attempts to give a positive spin on the challenge of designing and implementing policies that take cultural diversity into account. But organizations such as AIDESEP want more than "respect" towards their medical traditions; they want them to be recognized as equally valid as Western medical science. For indigenous organizations, interculturalidad is deeply intertwined with the "politics of recognition" (Taylor 1994) where indigenous identity itself becomes a strategy to claim political and social participation. This implies – among other things – support for research and for the advancement of indigenous medicine.

For Viaña (2010), governments in Latin America use the term interculturalidad in a superficial attempt to include indigenous people. This inclusion thus occurs in a subordinate way, with no questioning of the structures that have enabled and maintained indigenous people in this condition. Thus, government-promoted interculturalidad does not serve the best interest of indigenous people but helps to maintain the State's way of doing things "for" indigenous people (Viaña 2010). Similarly, Walsh (2009) argues that Latin American governments have co-opted the term interculturalidad so that it has become a new domination strategy of indigenous people. From Walsh's perspective, governments' claims to recognize cultural diversity and respect

[50] The MoH's approach is the subject of the following chapter.

cultural difference although the application of intercultural policies in various sectors (mostly education and health) maintain the colonial hierarchy that implies that "us" (the elites), allow "you" (indigenous people) to have your cultural differences acknowledged in specific areas of governance (Walsh 2009). This approach aims to make indigenous people feel included in the broader society without major substantial changes.

In many instances, government officials use the term "intercultural" to claim their openness towards indigenous people, when there might not be such openness in the way they design and implement policies. Similarly, several indigenous organizations –like ADIESEP– might be adopting the same limited interpretation of intercultural policies. Indigenous organizations also appear to be grappling with the potentially revolutionary implications of the term intercultural. For example, if we analyze the various instances when the PSI and its major spokesperson Juan Reátegui use the term "intercultural" to discuss health care, there is a focus on having indigenous medical traditions recognized, indigenous healers acknowledged as potential partners for addressing health needs, and having both sets of medical traditions used at a health facility. This implies that indigenous medical traditions are –to begin with– acknowledged, respected, accepted and promoted by the government. At this point, AIDESEP's PSI is not demanding broader political changes in the education of medical professionals, at least not yet. The project began with a push to train indigenous people in both sets of medical traditions.

2.3 RECOVERING INDIGENOUS MEDICAL PRACTICES AND BUILDING BRIDGES WITH WESTERN HEALTH CARE

Increased political organization has promoted efforts to recover traditional medical knowledge and recognize practices among several groups, such as the Tukoanos in the Colombian Amazon (Jackson 1995), the Shuar in Ecuador (Uquillas 1985), the Aymaras in Bolivia (Ramírez Hita 2009), the Maya, Xinka y Garifunas of Guatemala (FondoIndígena 2010) and indigenous Amazonian groups in Peru, represented by AIDESEP.

As we have seen in earlier sections, the recovery of indigenous medical practices has been a major axis of work for the PSI. In 1992, with the financial support of the Nordic Agency for Development and Ecology (NORDECO), the PSI developed a project to recover traditional medical practices that appeared to be forgotten by younger generations (Hvalkof 2003). As mentioned earlier (sub section 2.2.1) , in a first survey of indigenous medical practices in the 1990s, Reátegui and his team found that although some indigenous communities had become highly reliant on Western medicine (it was hard to find shamans), in other communities – mostly the more isolated ones – there continued to be a wide diversity of indigenous specialists.

In the context of NORDECO's project and with the support of indigenous communities in the Eastern Amazon, the PSI team registered the different indigenous specialists and organized workshops so that the specialists could exchange knowledge [51] (Hvalkof 2003). AIDESEP wanted to prevent the disappearance of indigenous medical practices in indigenous communities, due to the presence of Western health services that discouraged the use of indigenous medicine.

[51] For a detailed description of this Project, read "El desarrollo del proyecto PSI-AIDESEP" by Thoma Skielboe in: Hvalkof, S., Ed. (2003). Sueños Amazonicos: Un Programa de Salud Indígena en la Selva Peruana. Copenhagen, NORDECO (pp.106-119)

AIDESEP's concerns for indigenous peoples' progressive oblivion of indigenous medical practices were grounded in experiences of dispossession in the Peruvian Amazon. Indigenous medical practices are just one of several cultural practices that have become obsolete or that are hindered due to the presence of foreigners like missionaries who rejected the use of indigenous medical practices and forbade other non-European behaviors. For Juan Reátegui, years of missionary activities dissuaded the use of traditional medical practices and this has taken a toll in indigenous people's use of them. Traditional medical practices have been classified as the "devil's doing" both during colonial and contemporary times (Taussig 1987; Gow 1994). For example, during the 1980s missionaries banned shamanistic practices:

> Protestant missionaries of the Summer Institute of Linguistics (SIL) at the Kulina village of San Bernardo on the Peruvian side of the Purus River are reported to have banned the practice of traditional shamanism for curing, and have trained a Kulina man as a "nurse" or *sanitario* for the village (Pollock 1996:337).

Missionaries have played a key role in "the dislocation of indigenous populations and the breakdown of their own organizational and cultural categories", but they are not the only ones (Stenzel 2005). Health professionals have also contributed in dissuading indigenous peoples from practicing traditional medicine, and it has often resulted in indigenous youth feeling ashamed and being uninterested in learning traditional medical treatments (Hvalkof 2003). For example, when AIDESEP decided to train a group of young people as Intercultural Nurse Technicians, some of them were not very receptive to learning indigenous medical practices, for they wanted to become Nurse Technicians, not Intercultural Nurse Technicians (Interview 2008, Cynthia Cárdenas).

However, it is not possible to say that traditional medical practices have been totally abandoned. Studies among indigenous groups like the Matsigenka (Rosengren 2002) or the Ese'Eja in Peru show continued use of indigenous medicine (Desmarchelier, Gurni et al. 1996).

For example, in his research among the Kulina Indians, Pollock found that the ban on shamanistic curing put in place by missionaries on the Peruvian side of the border "appears to have had little effect on local practices at the very least, individuals who need traditional treatment by shamans come to Maronaua or another village on the Brazilian portion of the river" (Pollock 1996:337). Yet, forbidding indigenous medical practices is not based only on religious grounds, it is also based on racist principles.

Studies in various colonized areas of the world show that attitudes of condescension and racism towards indigenous local populations went hand-in-hand with the idea that their local medical practices were either non-existent or non-efficacious in addressing health needs (Packard 1997). In Taussig's book Shamanism, Colonialism, and the Wild Man: A Study in Terror and Healing (1987) the author describes how 16th century Spaniards considered indigenous medical practices as "sorcery". The Spanish church and administrative authorities thought it imperative that indigenous people become Christians and it was necessary to get rid of primitive practices, which included indigenous ways of healing (Taussig 1987). Taussig (1987) narrates how the local bishop instructed his priests to remove all the "instruments" from Indian sorcerers and prohibit their dances and songs in order to stop their demonic influence. Priests destroyed indigenous healers' drums, deer heads, and feathers, because as instruments of the devil, they brought the memory of paganism.

The elimination of indigenous medical practices throughout the Amazon (which included shamanism) because they were "*cosas del demonio*" ("devil's doing") persisted well beyond colonial times (Rosengren 2002). In many places throughout the developing world, missionaries and later, state officials, dissuaded the use of indigenous medicine just as colonial authorities did in the past (Green, Jurg et al. 1994; Stewart and Strathern 2004). AIDESEP's current concern to

rescue indigenous medical practices and protect indigenous knowledge from further loss must be understood in the context of the negative colonial experiences of the past.

Indigenous medical practices in the Peruvian Amazon are not overtly repressed as before, but several of the ideas used to justify doing away with them persist (Rosengren 2002). These ideas are the basis used to marginalize indigenous people throughout the Americas and thus, it is not a coincidence that health care has become a suitable arena for advocating recognition of cultural differences (Ruiz 2006). Demands for intercultural health services are intertwined with AIDESEP's expectations to have a national health care system that does not simply accommodate cultural differences, but constructively engages with cultural differences and –in the process– responds to the transformative politics of current indigenous social movements in Latin America and elsewhere (Buetow 2004).

AIDESEP's efforts to have a national health care system that respects and incorporates indigenous medical practices are not unique. Espinosa and Ogazón (2010), reviewed intercultural health efforts promoted by indigenous organizations in Latin America and argued that the basis of such efforts was to establish a more equitable relationship of power between the State and indigenous people. Intercultural health has in some instances become a core issue in indigenous political demands. In Bolivia, Evo Morales' government issued a health plan aimed at "dismantling colonial structures and developing an intrinsically sovereign national health system that includes the incorporation of traditional medicine" (Johnson 2010: 144). Thus, indigenous demands for intercultural health imply recognition of the validity of their traditional medical practices, and the comprehensive and respectful combination of them with Western approaches to health care.

In an approach similar to AIDESEP's, Ecuadorian indigenous organizations have argued that health care provision ought to respect indigenous social representations and be community-led (Lacaze D. 2002). Community participation in the decision-making processes of health care provision in indigenous communities is another important demand of indigenous organizations in various Latin American countries. Espinosa and Ogazón (2010) explain that community participation is a way through which indigenous people are recognized as social actors seeking inclusion and visibility. For some authors, like Lacaze (2002), sometimes indigenous organizations forget to stress the right to participation and rather focus on issues of compensation. Lazace (2002) explains that there is a focus on the political perspective of integration:

> …indigenous organizations tend to focus on the issue of health almost always from a more political than technical perspective. This is a political struggle to claim or get the state to provide support services that somehow, compensate for damages caused by the forced integration processes suffered by indigenous people and their current low status in the national society (p.168).[52]

This implies that in Ecuador indigenous organizations had made the mistake of framing their demands around intercultural health as getting the government to acknowledge the past mistreatment of indigenous people and compensate indigenous people for the marginalization of their culture. Rather, indigenous organizations in Ecuador could focus – as AIDESEP is doing – in the right of indigenous people to receive better and more appropriate health care, without ignoring the discrimination and marginalization indigenous people are still subject to.

[52] "Por otro lado, las organizaciones indígenas tienden a enfocar el tema de la salud casi siempre desde un ángulo más político que técnico. Se trata de una reivindicación o lucha política para conseguir que el estado cumpla con proveer servicios de asistencia que, de alguna manera, compensen por los daños ocasionados a través de los procesos de integración y su situación actual en la sociedad nacional."

Stephens et al. (2005) argue there is a need to look beyond intercultural approaches as a solution to address indigenous peoples' health needs, in order to acknowledge that indigenous people "are systematically marginalised within their own nation states; they are rarely given the opportunity to represent their own perspectives and understandings of their health and their views on the actions to be taken to improve it" (p.12).

For AIDESEP, one way of recognizing indigenous people's right to have their own perspectives of health recognized is through the allocation of health workers who are respectful of local ways, and who are willing to work in indigenous communities. The Peruvian MoH has recognized a lack of health personnel who are trained in intercultural approaches at health facilities providing services for indigenous people (Mora and Villavicencio Rivera 2006). Despite the efforts of the MoH, this problem has not been adequately addressed, and most non-indigenous health workers tend to discriminate and look down upon both indigenous sanitary and medical practices (MINSA 2010). The disregard for indigenous medical practices often comes hand in hand with discriminatory practices towards indigenous people within the health system (Espinosa 2009).

Ramírez Hita (2009) explains that when indigenous organizations in Bolivia advocate for an intercultural approach to health care, they are doing so as a way of contesting and resisting a medical model that mistreats indigenous people both in corporeal and ideological terms. This implies not only that indigenous understandings of privacy or touching are not respected, but also their ways of understanding the cause of an ailment are often ignored. In an interview, one of AIDESEP's PSI technical advisors Cynthia Cárdenas told me about a pregnant woman from the Awajún ethnic group who came to the health facility with contractions. When examining the woman, the midwife introduced her fingers into her cervix and broke her water to accelerate the

birthing process. The midwife did not ask the woman's permission. From the Awajún's perspective, a baby will come to this world when he/she feels is time to do it. By breaking the waters with her fingers, the midwife was accelerating the birthing moment of the baby. The Awajun woman ran away from the health post when the midwife left the room, and gave birth at home.

Situations like the one described above are –unfortunately– not rare, and in the Peruvian Amazon, such practices from health workers has lead indigenous people to distance themselves from health centers because of fear of mistreatment and discrimination (Anderson 2001; INS 2008; MINSA 2010). There is little capacity for accommodation of indigenous culture on the part of health workers and health institutions (Marques Hokerberg, Piraccini Duchiade et al. 2001). If intercultural health is –as AIDESEP proposes- about having two medical systems working side by side, it is crucial to have health workers prepared to implement such a system. Ideally, health professionals who are assigned to work in indigenous areas of Peru should receive some training or at least a crash-course on indigenous medical systems, cultural competence and intercultural health. Rather than waiting for the state to respond and do something about it, AIDESEP developed a program to train indigenous youth as Intercultural Nurse Technicians in 2003.

2.4 THE PROGRAMA DE FORMACIÓN DE ENFERMEROS TÉCNICOS EN SALUD INTERCULTURAL AMAZÓNICA (PFETSIA)

By the early 2000s, the PSI had completed an effort to train indigenous health promoters who were to become "bridges" between health workers and indigenous people. The training

aimed to establish connections between the different understandings of disease causation and treatment between these two groups. By the year 2000, it had become apparent to AIDESEP that this effort was not enough. Health promoters trained by AIDESEP were active while the project lasted, but once funding (and follow-up visits) ended, these health promoters were not incorporated into the health care system (as the PSI hoped) and gradually their involvement in health issues faded away.

One of the lessons from this experience was that health professionals do not always respect health promoters' suggestions given they are seen as "unskilled" health workers. It became necessary to develop a new strategy if the PSI was to improve both the quality of the health services provided for indigenous people and continue in their efforts to rescue indigenous medical traditions (Reategui 2005). Thus, the idea of creating a health degree in intercultural health arose. At first, Juan Reátegui considered the creation of an Amazonian indigenous university where the degree in intercultural health would be offered at the college level (Reategui 2008). Eventually, the PSI team decided that they could start by training a group of indigenous youth as professional technical nurses with an intercultural approach (Rodriguez Torres, Valdez Felipe et al. 2009). The young people would afterwards return to work in their communities as health workers (AIDESEP 2010).

The academic advisor of the project, Alfredo Rodriguez, suggested that if the students were to have the term "intercultural" in their degrees, they had to be equally educated in both medical systems. They would receive lessons according to the national curricula for nurse technicians (*enfermeros técnicos*) and a new one created specially for the project, which would be taught by indigenous medical specialists (Rodriguez Torres, Valdez Felipe et al. 2009). Upon completing the courses, these intercultural nurse technicians would not only be health

professionals acquainted with the reality of indigenous communities (since they have been born and brought up in one) but also professionals capable of engaging with the communities' ethno-medical systems and with other health professionals.

Supported by NORDECO and the *Fundación Karen Elise Jensen*, the PSI launched an educational program in 2003 aimed at providing technical education to indigenous youth, so they could provide culturally appropriate health services in indigenous communities (Rodriguez Torres, Valdez Felipe et al. 2009). In a documentary about this project "Medicos y Sheripiaris: Un Programa de Salud Intercultural en la Amazonía Peruana", the Project Coordinator, Isolina Valdes explains the rationale of educating indigenous youth as INTs:

> *We want this project to train intercultural health technicians because we think: "Who else but an indigenous person would be close to the communities? But if this indigenous person is professionally trained and in turn, knows the two medicines: Western medicine and indigenous medicine, the quality of care delivered to the communities will be much better, because they will be closer to their people, and will use the same things as they use and not come to implement a system from outside, with no respect for the systems in the communities* [53]*"* (AIDESEP 2010).

In order for students to obtain the degree of *Enfermeros Técnicos en Salud Intercultural Amazónica* (Intercultural Nurse Technicians), a career that until then did not exist in Peru, it was necessary to submit a great deal of paperwork to the Ministry of Education (MoE). After a long process of negotiation with the MoE to ensure the three-year curriculum would be recognized officially as a technical degree, the local indigenous organization called OIRA (*Organización Indígena Regional de Atalaya*) started to recruit indigenous youth. The main eligibility criterion was that candidates had to belong to an indigenous ethnic group and officially presented as a

[53] Nosotros con este proyecto queremos formar técnicos de salud intercultural porque creemos que quien mas estaría cerca a las comunidades es un propio indígena. Pero si este indígena profesionalmente capacitado y a su vez, está manejando las dos medicinas: medicina occidental y medicina indígena, la calidad de atención a las comunidades va a ser mucho mejor, porque estarán más cerca a su pueblo, usaran lo mismo de ellos y no habrá el hecho de venir un sistema e implantar lo que hacen afuera sin respetar los sistemas propios de las comunidades."

candidate by an indigenous federation. The candidates were also required to have completed their secondary studies had to be willing to invest three years away from their communities pursuing a technical degree in Atalaya. Twenty indigenous students belonging to three ethnic groups, the Yine, Shipibo, and Ashaninka were selected to be part of this pilot educational project "*Programa de Formación de Enfermeros Técnicos en Salud Intercultural Amazónica*" (PFETSIA).

The Pilot project began in 2005 in the Province of Atalaya, where the PSI had been working for several years. The goal of the program was to educate youths as intercultural nurses who would be well-versed in both Western and indigenous medicine. According to Rodriguez (2008, interview) this would give them an advantage in comparison to other health workers who had been exclusively trained in biomedicine and were often unprepared to provide health services for indigenous people.

The PFETSIA consisted of a three-year fellowship for young indigenous people to train as Intercultural Nurse Technicians. The program complied with the government-recognized curricula for nurse technicians, and was complemented with courses in indigenous medical techniques, epistemologies, pharmacology and indigenous medical practices (such as diets and use of hallucinogenic plants) (AIDESEP 2011). The indigenous part of the curricula was taught by taking the students to indigenous communities in the area. In the communities, the students would meet with indigenous healers and learn from them how to select medicinal plants, how to prepare the medicines and the appropriate dosages (AIDESEP 2010). A well-known shaman of the region known as Maestro Fermín became an important teacher for the students. He was a "*maestro ayahuasquero*" (an expert healing with ayahuasca) who taught students how to learn from the plant while in trance.

In an interview in 2010, one of the INTs named Hugo explained to me how he learned that the Renaco tree could heal bone problems during an ayahuasca session lead by the Maestro Fermín:

> *When you drink ayahuasca you feel as if you are under the effect of anesthesia, you don't feel anything. And that time [the maestro] made me see. "You are going to see all your bones" he says. A doctor came into my vision and he said "Well kid, what do you want to know? I am the bone doctor." "I want to know where I have a bone problem [liseado]" Well, he has come, he has touched me. And I wanted to hold his hand, but nothing I could not. He touched me and in the end, he said: "You have a bone problem here [in my foot]." And it was right I had a bone problem there. "Let's heal it." he said. I just watched, I did not say yes or no, I just watched him. "Let's heal it." "Ok" [Hugo replied]. "I'll be back in a minute." I saw him walk away and he went to a tree a very big tree with lots of branches. It was the Renaco tree. Then he takes a knife, as if he is a person and begins to scrape the bark. And he stays there scraping and then he brings it [the bark he has scraped]. "Put your foot like this" and he (plac!) puts the bark on my foot and covers it, like a doctor. But I wanted to see him, at least to touch him, but nothing! (…) Then a lady came; a midwife. It was as if it was a health center, with lots of specialized doctors. She told me "I am going to teach you all that has to do with maternal health" and she has explained to me "this plant is to be administered like this, you are going to prepare it like this"…"*[54]

Hugo explained to me how over several ayahuasca sessions he learned the properties of different medicinal plants and the way to prepare them. In some cases you had to boil their leaves and drink them as tea. In other cases you had to scrape the bark and drink it directly, all this he learned through his ayahuasca visions. Hugo also learned certain animals were the "mothers" of

[54] Te da como una anestesia te da, te sientes como anestesiados… y esa vez me hace mirar. "Vas a ver toditos tus huesos" me dice… ha venido un doctor en mi visión y me dice "bueno muchacho ,qué quieres saber. Yo soy el doctor de huesos." "Quiero saber dónde está liseado" "bueno, ha venido me ha tocado" yo le quería agarrar su mano pero nada. "él me ha tocado y total, acá tenía un liseado" Justo allí yo tenía un liseado [en el pie]. "Vamos a curarle, me dice." Yo me he quedado mirando, no le dije si sí si no. Me he quedado mirándolo. "Vamos a curarle" "Ya" "ahorita vengo". Lo he visto dando vueltas, se ha ido, se ha ido a un árbol. Asu, tremendo árbol, ramudo y total ha sido el Renaco. Y agarra, como si fuera una persona, agarra un cuchillo y le raspa. Se queda raspando… de allí le trae [lo raspado]. "Ponga tu pie así" Y me lo ha puesto (¡plac!) como un emplasto y me lo ha envuelto, como un doctor. Pero yo quería verle, agarrarle siquiera, pero nada!. Pucha madre. De allí ha venido una señorita, una obstetriz. Así como si fuera en el Centro de Salud, así. Con diferentes especialidades. Y me ha dicho "y te voy a enseñar todo lo que es materno" y así me ha explicado "esta planta vas a dar así, vas a preparar así."

particular illnesses. He learned you had to ask those animals to leave the patient alone so that the patient would heal.

The lessons learned during Ayahuasca visions are one example of how the INT training exposed students to different kinds of knowledge and ways of learning. The Maestro Fermin made the students follow certain dietary restrictions when planting or cutting particular plants used for healing. INT students had the opportunity to use plants on each other for steam baths and to treat fever.

Students did not receive theoretical courses on interculturalidad or intercultural health, for they learned about such an approach through practice. As we will see in Chapter 4, upon graduation it was up to the new INTs to use their knowledge of both medical traditions to better serve indigenous people. During the project, students were continuously encouraged by their academic tutor and their teachers to make connections between both medical traditions. For example, they would learn from a doctor about the machines and tools used to determine the length of gestation or the position of the baby, and then a midwife would show them how she went about calculating the same information. .

In the classes there were regular discussions about the importance of indigenous medical systems. This was meant to strengthen the student's identification with their own ethnic group and the indigenous organization's long-term goals regarding health care (Cardenas, *personal communication*, 2012). Indigenous leaders of the area were aware of the project and fully supported it. For example, in the documentary "Médicos y Sheripiaris" the president of the Atalaya indigenous organization explained the State's view of indigenous healers (locally called "sheripiaris"):

> "*Legally we indigenous people are not recognized. Who recognizes and respects our sheripiaris? "[This is] great sheripiari therefore deserves a salary (…) these are witches [they say]" They do not recognize us, they do not respect us our knowledge. So this is our knowledge and we have to proudly say "it belongs to us*" (Celin Cushi in:AIDESEP 2010)[55]

His statement was made in reference to the students being introduced to a community where they would provide health care. His statement shows that as an indigenous leader it was important for Mr. Cushi to argue in favor of the recognition of indigenous medical knowledge recognition and to take pride in indigenous medical systems. This recognition was an important part of the project and the education of INTs.

In a press release in 2007, AIDESEP clearly states that the role of INTs would be to strengthen the local indigenous health system

> They have studied Western medical technology and the medical technology of their own indigenous groups and will develop their ancestral indigenous knowledge incorporating positive aspects of Western medicine. In this way, they will strengthen the indigenous medical systems of the ashaninka/asheninka, tine and shipibo groups. (Servindi 2008) [56]

At the end of the three years, the fellows received a technical degree as Intercultural Nurse Technicians recognized by the Ministry of Education, making them eligible to work at any MoH facility (Rodriguez Torres, Valdez Felipe et al. 2009). Alberto Pizango, president of AIDESEP (2006-2014) states in "Medicos y Sheripiaris": "*Through this project, we have educated [human] resources so that the State can afterwards host them and ensure that health care finally reaches these communities* [57]**"** (AIDESEP 2010)

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[55] "Legalmente nosotros los indígenas no estamos reconocidos. a los sheripiaris ¿quién los reconoce? "un gran sheripiari por lo tanto se merece un sueldo" "esos son brujos [dicen]" No nos respetan no nos reconocen nuestro conocimiento. O sea ese conocimiento es de nosotros y como es de nosotros hay que decir "es de nosotros"."

[56] Ellos estudiaron las tecnologías de salud occidentales y también las de sus pueblos originarios y desarrollarán los conocimientos indígenas ancestrales incorporando los aspectos positivos de la medicina occidental. De esta manera fortalecerán los sistemas de salud ashaninka/asheninka, yine y shipibo.

[57]"Nosotros, a través de este proyecto, formamos recursos para que el Estado los acoja y que pueda hacer de que la salud finalmente llegue hasta estas comunidades."

AIDESEP's educational pilot project is a novelty in Peru although there have been similar examples in other parts of the globe. These examples provide insight into the challenges that arise in orchestrating these types of projects. In colonial times in India and Africa, colonial medics and administrators debated whether they should train local people in Western "cosmopolitan" medicine.

> In India, debates about whether medical education should integrate western and indigenous systems of knowledge began in the early nineteenth century. For many British officials, medicine and science were symbols of a civilizing progress, while for Indian nationalists, indigenous medicine became a site for anticolonial struggles for autonomy (…) Also debated in colonial medical policy was whether "natives" should be trained in western biomedicine to serve as health auxiliaries: Would they distort or alter biomedicine in dangerous ways? (Pigg 1997:262)

The questions raised by British officials are relevant to analyze the working experiences of INTs. In 2008, twenty young indigenous men and women graduated from the program[58]. By September 2010, when I began my fieldwork, half of the twenty INTs were working at governmental health facilities using their positions in the system to incorporate in creative ways their knowledge of indigenous medical practices into the health services they provided.

The INTs now working for the government are caught between the expectation of indigenous leaders and their jobs as health workers at a government health facility. Indigenous leaders want the INTs to help preserve indigenous knowledge and use indigenous medical practices. The technicians also have to follow national guidelines regarding Primary Health Care and meet the expectations of indigenous people coming to seek care.

In the INT educational program students received training in both medical traditions. They were taught the importance of using indigenous medicine and being proud of indigenous

[58] It was a pre-requisite to be admitted into the program to be a member of an indigenous community (Amazonian communities have a membership role) and be recommended by your local indigenous organization.

medicine. However, the program did not provide INTs with a roadmap for what to do in order to "transform" a health facility into an intercultural health facility. As we will see in Chapter 4, INTs are solely responsible for seizing opportunities and creating possibilities to build bridges between the two medical systems. In the process however, the broader goal of transforming the health system's recognition of indigenous medical practices gets lost.

In order to understand better what the Western medical system expects from the INTs, I will analyze the MoH's approach to interculturalidad in Peru in the following chapter and contrast this approach with the tasks health workers are expected to provide at a health facility.

2.5 SUMMARY

AIDESEP's PSI was first promoted in the 1990s by Juan Reátegui, an indigenous leader who himself graduated from a university with a degree in nursing. He realized the need to recover the use of indigenous medical knowledge and promote the use of indigenous medical practices in the Peruvian Amazon. The PSI project has two core lines of action: recovering indigenous medical knowledge and practices, and improving the quality of health care in indigenous communities. For Juan Reátegui the quality of health care provided by the state to indigenous people is not appropriate, mainly because health workers who work in such areas ignore people's ways of life. The health workers often look down on indigenous medicine and discourage indigenous medical practices.

For the PSI, health services for indigenous people have to be intercultural. The intercultural concept can mean different things to different actors, but interculturalidad is part of recent efforts on the part of indigenous organizations in Latin America to change the historical

marginalization and disempowerment indigenous people and their culture have been subjected to by state policies. Dialogue, respect and negotiation are part of definitions of interculturalidad.

For the PSI an intercultural health service is one that uses both Western medical care and indigenous medical practices to address health problems. In the context of intercultural health, medical systems complement each other and most importantly the medical systems should respect each other. No official documents of the PSI explain the shape that intercultural health services ought to have, the role each specialist should have, or how decisions about therapies would be made. However, by focusing their efforts in training nurse technicians as intercultural nurse technicians, it is apparent that from AIDESEP's perspective, health professionals do play a key role in the process of ensuring that health services are intercultural.

As part of the PSIs efforts to deliver intercultural care and recover indigenous medical practices, AIDESEP implemented a pilot project in the Province of Atalaya in 2005. Through this project, 20 indigenous youth received education in both medical traditions. Upon three years of training they received a degree as Intercultural Nurse Technicians and have been hired to work at governmental health facilities where – despite the government's rhetoric – there are still few opportunities to use an intercultural approach, as we will see in Chapter 4.

2.6 DISCUSSION

Interculturalidad is a relevant concept for indigenous organizations from Latin America; it implies opening up spaces for indigenous people to participate in the way policies are conceived and implemented. At its core, interculturalidad attempts to revert the historic trend of marginalizing indigenous organizations from the policy-making process.

For indigenous organizations, policies need to recognize and take into account the cultural characteristics of indigenous people. Through its Indigenous Health Program ADIESEP is advocating for the implementation of intercultural health policies that recognize the value of indigenous medicine at state-run health facilities. Having health professionals that understand indigenous medical practices and advocate for their recognition among other health workers are a central element for providing intercultural health care. However having such health workers is not enough to inform policy-making.

As we will see in Chapter 4 AIDESEP's indigenous health program needs to develop a more comprehensive strategy that will, on the one hand improve the quality of care for indigenous people and influence health policies to ensure that they respond to the health needs of indigenous people while securing their right to receive culturally-appropriate health care. Furthermore, AIDESEP's PSI needs to develop a strong argument focusing on the impact that poverty and discrimination has on the health status of indigenous people.

3.0 THE PERUVIAN HEALTH SYSTEM AND ITS INTERCULTURAL APPROACH TO HEALTH

In this chapter, I present the Peruvian MoH's conceptualization of the intercultural approach to health and the strategies the ministry proposes to implement it. Since the early 2000s, the MoH has taken a number of steps towards the adoption of an intercultural approach to the health services it provides. These steps, however, have stayed mostly at the level of norms and regulations that I will analyze in this chapter. The norms and regulations have not yet had much impact on practices and have not materialized into concrete actions in health care provision. The MoH's efforts show that intercultural health is not just the will of indigenous organizations in Peru. The MoH also responds to mandates for more intercultural sensitivity from international organizations such as the Pan American Health Organization (PAHO) that pressure governments to reduce health inequalities.

In the previous chapter I presented AIDESEP's understanding of intercultural health. I described AIDESEP´s INT training initiative to promote health services that combine indigenous medicine with Western medicine. AIDESEP wants the INTs to bridge Western and indigenous approaches to health care. While one core aspect of intercultural health lies in the provision of services that combine both types of medical systems, as we will see in this chapter, the strategies and rationale to enable this to happen differ. For instance, while AIDESEP highlights the importance of cultural recognition and a broader acceptance of indigenous medical practices, the

MoH focuses on practical aspects, such as ways to prepare health professionals to interact with indigenous specialists and treat patients jointly, when necessary. The MoH's vision of intercultural health might have some points of convergence with AIDESEP in terms of the broader goal of intercultural health. There is some convergence for example in the goal to make health services culturally-appropriate. As we will see in this chapter, however, there are dissimilarities in the strategies used to achieve this goal. In order to understand the Peruvian MoH's intercultural approach to health, this chapter will first analyze the social and political factors that prompted the development of such an approach from the perspective of the PAHO. PAHO is the regional branch of the World Health Organization (WHO) that sets the health priorities, establishes guidelines and provides technical assistance for the design and implementation of health policies in the Americas.

Based on official documents issued by the PAHO such as "Incorporación del enfoque intercultural de la salud en la formación y desarrollo de recursos humanos" (1998) and Harmonization of Indigenous and Conventional Health System in the Americas. Strategies for Incorporating Indigenous Perspectives, Medicines, and Therapies into Primary Health Care (2002), section 3.1 describes the three factors that contributed to the development of an intercultural approach by this organization. These factors are: increased political activism of indigenous organizations in the 1990s, increased evidence of the health inequalities experienced by indigenous peoples throughout the Americas, and increased acceptance that non-Western medicine can also improve the well-being of people. After describing the development of PAHO's approach to intercultural health, I will follow with an analysis of the intercultural health approach at the national level in Peru. My goal is to establish a connection between PAHO's guidelines and the development of an intercultural approach to health in Peru. The last section of

this chapter provides a discussion of the main critiques the top-down, state-led intercultural health efforts have received.

3.1 THE DEVELOPMENT OF THE INTERCULTURAL APPROACH IN THE PAN AMERICAN HEALTH ORGANIZATION

The use of the term "intercultural" to refer to health services that aim to combine two medical systems is something that became popular in the 1990s. The term intercultural began to be used by Ministries of Health, Non-Governmental Organizations and indigenous organizations throughout Latin America at that time (Ramírez Hita 2009). Intercultural health –just as the term interculturalidad – can take on different meanings and imply different strategies depending on the goals of the organization that promotes it.

The idea of providing intercultural health services gained strength during the 1990s, however certain aspects of the intercultural approach has its origins in earlier ideas about the need to find ways to combine western and indigenous medicine in health care provision. The combination of both medical systems constitutes a core component of the intercultural approach; however, it is by no means the only one.

The roots of the intercultural approach can be traced back to the 1970s when the WHO proclaimed "health for all by 2000." In order to achieve this goal, the WHO called for the integration of traditional healers into national health systems as a more effective means to deliver Primary Health Care (PHC). In this section, I will present PAHO's understanding of what constitutes an intercultural approach to health and why it is important to promote its use in the Americas.

3.1.1 THE INTEGRATION APPROACH

In the 1970s, the WHO promoted the participation of traditional healers in national PHC efforts. The rationale was that traditional healers could play a role in proving basic primary health care services, such as vaccination, because they were respected by communities and there was a limited number of health care professionals. The idea of bringing traditional healers seemed to be a good strategy to help fill a void and increase the number of trained health providers who were reaching out to the population. Traditional healers could promote key protective health behaviors such as hand-washing and provide basic preventive and curative care (WHO 1978; WHO 1978; WHO 1995). The integration approach involved two core strategies: identify traditional healers and promote their participation in health service provision in governmental health facilities.

The earliest efforts to integrate indigenous healers into Western-based healthcare services in Latin America occurred in the 1980s. During that decade, training programs for indigenous healers were widely implemented. In Brazil and Mexico for example, indigenous healers received training in oral rehydration therapy (WHO 1995). In Bolivia, traditional healers were appointed as staff at state health posts (Bastien 1982) and a similar project was implemented in the Colombian Vaupés (Jackson 1995). Maternal health was a key area for training midwives to follow biomedical protocols for birth in Mexico (Sesia 1996) and Guatemala (Maupin 2008).

The WHO stressed that effective integration of both systems entailed giving credit to the merits of both the traditional and the modern systems of medicine, ensuring “mutual respect, recognition and collaboration among the practitioners of the various systems concerned” (WHO 1978:16). In practice, however, most of the efforts to integrate both medical systems did little more than institute training programs for traditional healers. The traditional healers were

expected to quietly support the strategies planned by national health boards and international organizations (Ramírez Hita 2010).

For example, in Guatemala, the impact of training programs for midwives were studied by Maupin (2008) in the town of San Martín, Jilotepeque. Such programs aimed at reducing infant and maternal mortality. The author found that these programs did little to recognize the important knowledge that midwives have regarding maternal health and the role that midwives hold in their communities. This training program redefined the role of midwives as low-paid attendants of the health system. Midwives' knowledge, practices, and authority in the community were not fully taken into account. They were participating under the banner of an international agenda where they had to comply with the biomedical model of obstetric care (Maupin 2008).

The integration approach had other shortcomings besides the submission of indigenous healers as simple aides of broader agendas. The top-down nature of the integration approach left little or no room for the incorporation of an indigenous medical approach. In the context of integrating traditional healers into the national health system, healers were told how to treat specific health problems using a biomedical rationale. Efforts to incorporate local remedies into the treatment or prevention of health problems were absent. For instance, a report about how traditional healers were trained to help reduce levels of childhood mortality from diarrhea in Brazil shows that healers were taught to identify when a child is dehydrated and how to prepare and administer a simple homemade oral rehydration solution (Hoff 1995). There is no evidence of asking traditional healers how they used to treat dehydration according to their medical traditions.

Projects based on the integration approach led to situations in which the knowledge of indigenous people was ignored and the perspective of indigenous people was not taken into

account (Knipper 2006). Early efforts at the integration approach aimed at fulfilling health outcomes from a Western perspective using traditional healers.

Another shortcoming had to do with the way traditional healers were to become "agents" of national health systems. One common strategy was to give traditional healers a physical space within governmental health facilities (Bastien 1992; Castañeda, García Barrios et al. 1996). The rationale was that indigenous people trust traditional healers more than health workers and including traditional healers would make people come more readily to the health facility. Traditional healers would subsequently "recruit" their patients to receive other primary health care services such as vaccinations or prenatal care.

Ramirez Hita (2009) conducted a study in the early 2000s on the Intercultural Hospital in Tiquipaya, Bolivia. Health officials hired traditional healers and traditional birth attendants under the assumption that this would increase the number of indigenous people who sought care. Health authorities thought indigenous people did not come to governmental health facilities because they preferred to be seen by indigenous healers. Ramirez Hita's (2009) study shows that health authorities' assumptions were wrong. When indigenous people needed an indigenous healer, they would go to the healer's homes since they were already familiar with them and knew where they lived (Ramírez Hita 2009). Going to the health facility to receive the services of indigenous healers was a foreign idea to the community members. Ramirez Hita (2009) found that when indigenous patients go to a health facility they want to receive biomedical treatment and Western remedies for ailments like fever or toothaches. The "integration" of traditional healers into existing governmental health facilities was not an improvement in the quality of services indigenous people received. It also did not respond well to the way the indigenous population makes their healthcare decisions (Ramírez Hita 2009).

In Mexico, Jimenez et al. (2008) found another reason the integration approach was not successful. She argues that the integration approach was unsuccessful because of its failure to critically analyze the social contexts in which indigenous healers were to become part of the health system. A crucial element of the social context was the perception the health professionals had of indigenous healers. Such perceptions involved issues of race and class where health professionals considered themselves better prepared to address health problems than indigenous healers. Jimenez et al. (2008) found despite the efforts of an NGO in training midwives (*parteras)* in basic biomedical principles, doctors working at public hospitals in Morelos, Mexico chose to ignore the training of the *parteras. Parteras* learned they had to pretend they had not referred a patient to a doctor, so the doctors would not feel threatened by the encroachment of traditional healers into their realm of expertise (Jiménez, Pelcastre et al. 2008).

The Bolivian and Mexican examples show that health efforts oriented at integrating medical systems failed because those who designed such projects ignored the social context and the existing perceptions of indigenous healers and indigenous medicine by health professionals (among other reasons). Contemporary intercultural health efforts differ from past integration approaches in that they stress the importance of health professionals learning about indigenous medicine and cultural traditions.

3.1.2 THE INTERCULTURAL APPROACH

In the 1990s, increased political activism from indigenous organizations (discussed in Chapter 2), led to more articulate demands made on behalf of indigenous peoples in the Americas. In 1992, PAHO launched the "Health of the Indigenous Peoples Initiative", where indigenous organization from different countries in the Americas participated to address the

poor health of indigenous people and the role that indigenous organizations ought to play in addressing the situation. The meeting ended in a resolution that begins by stating the health and living conditions of many indigenous peoples are deficient:

> "[T]he living and health conditions of the estimated 43 million indigenous persons in the Region of the Americas are deficient, as reflected in excess mortality due to avoidable causes and in reduced life expectancy at birth, which demonstrates the persistence and even the aggravation of inequalities among indigenous populations in comparison with other homologous social groups…" (PAHO 1993).

This situation demanded actions from national governments and indigenous organizations present at the meeting wanted to ensure their demands were heard. Thus, a resolution was proposed called "Resolution V - The Health of Indigenous Peoples of the Americas" which was drafted by indigenous organizations at the 1992 meeting. It captures the key demands of indigenous organizations in regards to promoting health services that are appropriate for indigenous people. According to the resolution, practitioners should take a holistic approach to health (and not only a biomedical one). Health services ought to be based on indigenous people's right to self-determination and the need for respect and revitalization of indigenous cultures. There should be reciprocity in the relations between the state and indigenous organizations and indigenous people have the right to systematic participation (PAHO 1993).

Resolution V is one outcome of the growing indigenous activism in Latin American countries in the 1990s. Such activism led to the development of new paradigms in public policy as Latin American societies moved towards an increased recognition of cultural diversity. Policies that only acknowledged the culture of the dominant social group were criticized, and the term "intercultural" became commonplace in several governmental policies. At the international level, PAHO began to advocate for the development of new paradigms that went hand in hand with the demands of indigenous groups and the societal changes the region was undergoing. At

the same time, another factor contributed to the development of the intercultural approach to health: the realization that there were huge health inequalities experienced by indigenous people in the region.

According to PAHO (1998), until the 1990s health care provision in the Americas was based on a monocultural paradigm that ignored the specificities of the different —especially indigenous-- groups that inhabited the region. As a result of the use of a monocultural paradigm, the health status of indigenous people was poor in relation to the rest of society. One of the reasons the health status of indigenous people was poor was that health services were not culturally-appropriate for indigenous people (PAHO 1998). This required a reevaluation of the approaches that had been used – up to the present – to promote health care.

For the PAHO, health systems in the Americas were always designed as if the population it served was homogenous. Services largely responded to the needs of the urban population, ignoring the specificities of marginalized groups such as indigenous people (PAHO 1998). Furthermore, the conceptualization of health and illness responded to the biomedical paradigm embraced by dominant "westernized groups." This paradigm treats illnesses in a fragmented way; indigenous people treat illness in a more holistic way as outlined in Resolution V (PAHO 1993; PAHO 1998).

The intercultural approach to health is an alternative to the monocultural approach (PAHO 1998). It is different from the integration approach because it is not only about “incorporating” indigenous healers into the national health system. The intercultural approach implies the transformation of the health system from a system based on a purely biomedical paradigm of care into one that integrates other medical paradigms (PAHO 1998).

Although most Latin American countries legally recognize ethnic, linguistic and cultural diversity, this is not translated in the way health services are provided. For instance, health care providers are educated within a predominantly biomedical and biotechnological approach, and health care providers ignore the contributions that indigenous medicine can make to improve health care provision. As a result, health professionals are poorly prepared to work in plurilingual and pluritiethnic contexts. In this light, PAHO assessed there was limited availability of bilingual health professionals (1998). Furthermore, PAHO recognized that health services are usually not appropriate for indigenous contexts where other medical traditions and medical specialists are available. As a result, national health systems often provide services but exclude those who are "culturally different" from the mainstream culture (i.e.: indigenous people).

Monocultural health services do not accommodate the specific characteristics of indigenous contexts in terms of schedule, language, and concepts of illness and health (PAHO 1998). Moreover, a monocultural approach to health rejects indigenous health systems or greatly underestimates indigenous knowledge (PAHO 1998). An intercultural approach to health care attempts at changing all these characteristics (employees who are poorly trained, health services delivered based on urban schedules and only with biomedical approaches to care), making services respectful of the knowledges, beliefs, and practices of indigenous people. A health system with an intercultural approach is staffed by health professionals who understand and use local concepts of health and illness and are capable of establishing respectful and equitable relationships with indigenous specialists (PAHO 1998). Intercultural health services aim at identifying and acting upon the specific needs of indigenous peoples and draw upon the support of community resources. This enables indigenous organizations to participate in health policies for indigenous people via participatory avenues (PAHO 1998; MedicusMundiNavarra and SSL

2012). Such participatory avenues can take the shape of community meetings where people express their health needs and negotiate the way health services can be delivered: schedules, language, etc.

3.1.2.1 CHARACTERISTICS OF PAHO'S INTERCULTURAL APPROACH

There are different ways of assessing what constitutes an intercultural approach to health care. At the policy level, an intercultural approach for the PAHO is one that includes indigenous perspectives, cultures and worldviews in the analysis of living conditions and health status and in the formulation of strategies to meet the needs of indigenous people (PAHO 2002:17). This implies that an intercultural approach recognizes the importance of characterizing the differences within the population and the importance of understanding the role that ethnicity, culture and the cosmic vision of peoples play in relation of the health dynamics of the particular group (PAHO 2002:19).

Furthermore, for PAHO, it is crucial to incorporate the perspective of indigenous organizations when governments promote the incorporation of an intercultural approach in health services. Ideally, intercultural health efforts ought to be the reflection of a genuine and respectful interaction between governmental offices, indigenous people and other social actors. This will not only enable the conservation of indigenous knowledge but will also consolidate a collaborative way of working among these three sets of actors (government, indigenous people and other social actors) (PAHO 1998:26).

At the level of health service provision, PAHO proposes that an intercultural approach should be reflected at many levels of health service such as treatment, rehabilitation practices, disease prevention, and health promotion activities. In order for these activities to be intercultural, PAHO states that they ought to be based on the "recognition, respect, and an

understanding of the social and cultural differences between peoples, their knowledge, and their resources" (PAHO 2002) Thus, an intercultural approach is one that both respects and revitalizes indigenous culture (this is similar to what AIDESEP proposes). Overall, for PAHO, an intercultural approach is one where health strategies are improved by incorporating indigenous perspectives, medicines, and therapies into national health systems (PAHO 2002:1).

These last statements resonate with the integration approach (discussed earlier in this section). However, there are several differences since an intercultural approach attempts to be much more than incorporating indigenous healers into the national health system by training them to use biomedical primary health care practices. As a matter of fact, PAHO states that the term intercultural implies a rejection of the term "integration." PAHO prefers the term "harmonization" of medical systems which, is synonymous with conciliation, interrelation, consensus-building, or mediation between the medical systems (PAHO 2002). An intercultural approach is one that "develops actions aimed at the harmonization of indigenous health systems with their many health providers and practices, and the conventional health system" (PAHO 2002:9).

Discussions regarding the differences that arise between the integration approach and the intercultural approach depend on whether or not health authorities recognize that indigenous medical traditions and knowledge are effective (Cunningham 2002; Lacaze D. 2002; Reategui 2008). From the perspective of some indigenous organizations, the integration approach did not necessitate the validation of indigenous knowledge by the health sector; it also did not challenge the social and symbolic context that places indigenous healers at a disadvantage and in an inferior position vis-à-vis Western-trained health professionals (Cunningham 2002). For Lacaze (2002), the integration approach has slowly transformed into what we now call the intercultural

approach. He summarizes the differences between integration and validating different approaches to health in the following quote:

> After more than 20 years, the proposed integration of traditional medicine into the formal health services has significantly evolved and, along this process of reflection and adaptation, there are number of new elements that were not considered at the beginning. Among these, and perhaps one of the most fundamental, is the need to accept the health concepts of indigenous peoples as valid and used as the backbone for promoting health in the broader context of its own development. Rather than integrating traditional medicine into the formal health system, it is appropriate to seek ways to support and strengthen their own development and cooperation between these two forms of medicine. (p.166) [59]

Intercultural health efforts promoted by indigenous organizations recognize and support indigenous medicine while state-driven intercultural health efforts unfortunately do not have this positive approach to indigenous medicine.

In the following section, I will present the strategies developed by the Peruvian MoH in its efforts to comply with PAHO's guidelines on intercultural health services. The point of departure for any intercultural health policy are the social policies targeted at indigenous people. An intercultural approach advocates that health policy ought to be rooted in indigenous peoples' own culture, language, values, worldview and system of knowledge (López 2009). At the same time, health professionals ought to be receptive, open to and appreciative of other knowledges, values, cultures and traditions (López 2009). Definitions like this come across as poetic and idealistic, making them ineffective when it comes to proposing concrete guidelines to implement the intercultural approach to health services.

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[59] Después de más de 20 años, la propuesta de integrar las medicinas tradicionales dentro de los servicios oficiales de salud ha ido evolucionando bastante y, a lo largo de estos procesos de reflexión y adaptación, se ha presentado una serie de elementos nuevos y no considerados al principio. Entre éstos, y quizás uno de los más fundamentales, está la necesidad de aceptar los conceptos de salud de los pueblos indígenas como válidos y que se utilicen como eje central para promover la salud en el contexto amplio de su propio desarrollo. Más que la integración de la medicina tradicional dentro de los sistemas oficiales de salud, se trata de buscar formas adecuadas para apoyar y fortalecer su propio desarrollo y la cooperación entre esas dos formas de medicina.(Lacaze D. 2002:166)

3.2 THE INTERCULTURAL APPROACH IN THE PERUVIAN MINISTRY OF HEALTH

As an international organization, PAHO's role is to promote the use of specific health care approaches by countries in the Americas. PAHO is also supposed to support countries in designing frameworks and executing models of care that can help reduce the barriers many indigenous people face in achieving health equity, as well as access to health services. Finally, PAHO's role is to provide countries with technical assistance to develop methodologies and tools that facilitate the incorporation of indigenous perspectives, medicines, and therapies into national health systems, particularly in primary health care (PAHO 1998). As a member state of the PAHO, Peru has followed several of its guidelines regarding intercultural health.

In Peru, the main efforts to promote an intercultural approach can be seen at the level of creating specialized centers within the MoH, and issuing norms and regulations about intercultural health. In the following section, I will analyze various official documents in order to understand the rationale behind the use of an intercultural approach and the strategies proposed by the MoH.

3.2.1 FROM TRADITIONAL MEDICINE TO INTERCULTURAL HEALTH

In the late 1990s, the MoH created the *Instituto Nacional de Medicina Tradicional* (INMETRA - National Institute of Traditional Medicine), a research institute that focused on the study of the chemical properties of medicinal plants (Revilla 2009). The INMETRA was for many years the only institution within the MoH that somehow tried to create bridges with indigenous knowledge and practices.

In 2004, the INMETRA was renamed the *Centro Nacional de Salud Intercultural* (CENSI - National Center for Intercultural Health). In addition to the name change, there was also a shift in the roles that CENSI was expected to fulfill. On the one hand, CENSI continued with INMETRA's work regarding the study of alternative and complementary medicine[60], but it also took up the responsibility of promoting intercultural health within the MoH. Since its creation, CENSI was expected to move beyond being a research-only institution to become a policy-making one. As part of its mandate CENSI had develop legislation favorable to intercultural health, for example:

> suggest policies and norms related to intercultural health, (…) and to the integration of traditional medicine, alternative medicine and complementary medicine with biomedicine, in order to contribute in improving people's health[61] (CENSI 2009).

By 2010 when I began my fieldwork there was very little that CENSI had managed to do at the policy level (Salaverry, 2010 – Personal Interview). CENSI had produced some publications and organized conferences around intercultural health, but it had not managed to make serious inroads into intercultural health policies in terms of human resources or health care provision. CENSI had, however, published a Technical Norm regarding the protocols that ought to be followed by health workers should they find or be informed about any indigenous groups in voluntary isolation in the regions where they work[62]. Nevertheless, there were other offices

[60] The CENSI's research on traditional medicine focuses in finding the chemical properties of medicinal plants and documenting the traditional way of preparing such plants.
[61] El Centro Nacional de Salud Intercultural (CENSI) es el órgano técnico normativo del INS que tiene como objetivo proponer políticas y normas en salud intercultural, así como promover el desarrollo de la investigación, docencia, programas y servicios, transferencia tecnológica y la integración de la medicina tradicional, medicina alternativa y medicina complementaria con la medicina académica, para contribuir a mejorar el nivel de salud de la población.
[62] Normas y Guías Técnicas en Salud: Indígenas en Aislamiento y Contacto Inicial. C. Cabezas Sánchez and N. Cueva Maza. Lima, Peru, Ministerio de Salud del Perú. MINSA (2008).

within the MoH that began to make efforts to comply with the PAHO guidelines about intercultural health, such as the Health Promotion Office (*Dirección de Promoción de la Salud).*

By the early 2000s, there was more awareness within the MoH about the health inequalities that affected indigenous people. During the early 2000s, the Epidemiology Office conducted several studies on the health status of various indigenous groups. These studies were called ASIS "*Análisis de la Situación de Salud*"[63] and were carried out in the Amazonian region. These studies corroborated the need to design specific strategies to reduce health disparities. There are two relevant issues to highlight about the ASIS studies: all were conducted on indigenous groups from the Amazon (and not on Andean populations), and intercultural health is associated with indigenous people. In Peru, Amazonian people – as opposed to Andean people – appear more "exotic" and "different". This is a trend within the MoH and its approach to interculturalidad.

In 2004 the MoH formed an "extraordinary commission" for the Amazon region[64] to design an action plan for providing health care for indigenous people of the Amazon (Meentzen 2007). This commission was under the leadership of the CENSI and it made the health of indigenous people from the Amazon an important target group of intercultural health projects. In that same year, CENSI issued a Ministerial Resolution creating the *Estrategia Nacional de Pueblos Indígenas* (National Health Strategy for Indigenous Peoples) (MINSA 2004)[65]. The aim of the strategy was to promote, coordinate, and implement actions aimed at reducing the existing

[63] Some of the Published Studies are: Análisis de la Situación de Salud del Pueblo Achuar. Lima, Dirección General de Epidemiología MINSA (2006); Análisis de Situación de Salud del Pueblo Matsigenka. Lima, Dirección General de Epidemiología . MINSA (2006); Análisis de Situación de Salud de la Provincia de Purús, Ucayali. Lima, Dirección General de Epidemiología MINSA (2008); and Analisis de la situacion de salud del pueblo Shipibo-Konibo. Lima, Oficina General de Epidemiologia MINSA (2002).

[64] *Comisión Nacional para la Salud Amazónica.*

[65] Neptalí Cueva, former director of CENSI consider that the principles of intercultural health should be applied to all health facilities in Peru and not just in those who serve indigenous people given that all different groups in the society have a particular culture that ought to be taken into consideration when providing health services.

health gap between indigenous people and the rest of the Peruvian population (Palacios Flores, Delgado Castro et al. 2008).

In the following years the MoH continued to show concern for the health disparities experienced by indigenous people. For instance, in 2005 the MoH created a Technical Office (*Unidad Técnica*) [66] to ensure that health services incorporated concerns about gender, human rights and intercultural relations. Several norms and regulations were also issued with the goal of diminishing discriminatory practices in state health services (MINSA 2005). Some regulations aimed at promoting the incorporation of certain indigenous medical traditions at health centers, such as the Technical Norm for Vertical Birth with Intercultural Adaptation ("*Norma Técnica para la Atención del Parto Vertical con Adecuación Intercultural*")[67] which allowed indigenous women to give birth according to their traditional practices within governmental health facilities (MINSA 2005). This is seen by the MoH as a crucial step towards a transformation of health services to better serve indigenous people, and complies with PAHO's definition of intercultural health which states that "Intercultural approaches to health aim at incorporating their [indigenous people's] perspectives, medicines, and therapies into the national health systems" (PAHO 2002:1).

In 2006, the year following the publication of the norm about vertical birth, the MoH issued another Technical Norm related to intercultural health: the Technical Norm on Human Rights, Gender Equity and Intercultural Heath ("*Norma Técnica de salud para la*

[66] Constitución de la Unidad Técnico Funcional de Equidad de Género, Derechos Humanos e Interculturalidad. RM 030-2005/MINSA. Ministerio de Salud del Perú. Lima, MINSA.

[67] Technical Health Norms in Peru are compulsory and are intended to standardize the way health workers (1) provide services for different age groups (new born, adolescents, old age), (2) treat major infectious diseases (TB, malaria, HIV/ADIS, Lleishmaniasis, etc.) and (3) provide care to specific groups such as pregnant women.

transversalización de los enfoques: Derechos Humanos, Equidad de Género e Interculturalidad en Salud").

The goal of this Technical Norm was "to ensure that the Human Rights, Gender Equity and Intercultural approaches are transversal to all policies, plans, programs and activities of the health sector"[68] (MINSA 2006). It is believed this norm would "Contribute to the improvement of people's heath and reduce health inequality gaps"(MINSA 2006). In the following section, I will look specifically at the provisions regarding the implementation of an intercultural approach to health according to this Technical Norm.

3.2.2 INTERCULTURAL HEALTH IN THE MOH: RATIONALE AND PROPOSED STRATEGIES

The Technical Norm on Human Rights, Gender Equity and Intercultural Heath (hereafter referred to as "the Norm"), begins by explaining that one of the reasons to use an intercultural approach in health care is the persistence of discriminatory practices towards indigenous peoples at health facilities. Such practices – it explains – discourages indigenous people from using governmental health services. The Norm explains that discriminatory actions have negatively impacted indigenous populations:

> "The existence of a plurality of ethnic-cultural knowledges, practices, own resources and therapists and other official health systems has generated in the agents of the official health system, a discriminatory behavior and an authoritarian relationship that have negatively impacted traditional health systems and the members of these sectors of the

[68] Contribuir con la mejora de la salud de la población, la reducción de las brechas de desigualdad en salud y con el ejercicio pleno del derecho a la salud sin discriminación alguna mediante el establecimiento del marco normativo para la transversalización de los enfoque de derechos humanos, equidad de género e interculturalidad en las políticas, lineamiento planes, programas, y actividades del sector.

> population who are rejected, not valued and excluded from the benefits of the scientific advances Western medicine." (MINSA 2006) [69]

In addition, the Norm states that in order to eradicate the discrimination and exclusion of indigenous people, it is necessary to adopt "affirmative action measures" in three areas: the training of human resources to better serve indigenous populations, the creation of opportunities for collaborative interaction between medical specialists of both systems, and additional research. Research – the Norm explains – ought to focus on understanding the social and cultural characteristics of the indigenous group with whom the health professional is working.

In terms of the training of human resources, the Norm proposes the following measure:

> "Promote among the agents of the Western health system, attitudes of respect to difference and diversity, as well as attitudes of recognition and appreciation of the contribution of traditional medicines." (MINSA 2006) [70]

Thus, the Norm acknowledges that doctors, nurses and other health professionals are a core component of intercultural health. These health workers ought to respect, recognize and appreciate the contribution of indigenous people's medical traditions to their health care.

The second measure proposed by the Norm focuses on an idea that we have seen in PAHO's guidelines, an area related to the "articulated work" of health professionals and indigenous healers. By "articulated work" I mean that health professionals and indigenous healers work jointly, in negotiation and conversation with each other. According to the Norm, an intercultural approach to health should "Ensure the interaction between the agents of the various

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[69] La existencia de una pluralidad de grupos étnico-culturales con conocimientos, prácticas, recursos y terapeutas propios y distintos del sistema de salud oficial, ha generado en sus agentes de este último, conductas discriminatorias y relaciones autoritarias en perjuicio de los sistemas de salud tradicionales y de los miembros de estos sectores de la población que son rechazados, menos valorados y excluidos de las ventajas de los avances científicos de la medicina occidental.

[70] Promover en los agentes del sistema de salud occidental actitudes de respeto a la diferencia y la diversidad así como de reconocimiento y valoración de la contribución de las medicinas tradicionales.

health systems to promote complementarity and mutual enrichment of health systems." (MINSA 2006) [71]

This implies that both health professionals and indigenous medical specialists should have opportunities to complement the work of the other and enrich each other's respective health systems. The Norm stresses an intercultural approach to health that requires the joint, complementary work between the "agents" of each medical system.

The third and last measure proposed in this Norm is that an intercultural approach to health requires knowing and understanding the local "social" and "cultural" factors practiced individually or collectively by an indigenous group. The Norm states that health workers have to incorporate these factors to improve health status:

> "Incorporate strategies to identify protective factors, both individual and collective, social and cultural that can potentially contribute to increase the conditions that are favorable to the health status of the members of the ethno cultural communities." [72] (MINSA 2006)

Which strategies ought to be used or what socio cultural practices should health workers identify are not explicitly stated. Furthermore, the Norm does not include any guidelines for how health professionals should encourage "socio cultural practices" that are protective or positive factors for people's health, such as in the case of diet or food taboos for Amazonian groups.

The Norm lays out an important aspect of the Peruvian's MoH understanding of intercultural health; it depends on the health professionals trained to implement it. There is no clear mention of how health workers should engage with community organizations to improve their current healthcare provision strategies. The measures that promote the collaboration

[71] Asegurar la interacción entre los agentes de los diversos sistemas de salud para promover la complementariedad y el enriquecimiento mutuo.
[72] Incorporar estrategias para la identificación de factores protectores, individuales y colectivos, sociales y culturales que potencialmente puedan contribuir a incrementar las condiciones que sean favorables a los estados de salud de los miembros de las comunidades étnico culturales.

between medical specialists do not mention how there might be limitations or difficulties to actually working in the suggested collaborative way. The expectations of health workers and indigenous specialists outlined in the Norm seem naïve and simplistic. The policy ignores the social, historical and cultural trajectories of each group, and this is also reflected in the challenges the INTs face in trying to bridge both medical systems (Chapter 4).

3.2.3 INCORPORATING THE INTERCULTURAL APPROACH IN PERU

In addition to the Norm analyzed in the previous section, there are other documents issued by the MoH that present a range of strategies for implementing an intercultural approach in primary health care. In this section, I will analyze both the Norm and the document called Health Promotion Model, published by the Office of Health Promotion of the MoH in 2004.

I will present the key strategies proposed in the selected documents and identify where lies the responsibility of implementing an intercultural approach at health facilities, according to each document. Although the strategies outlined in official documents are mandatory procedures for all health workers, none of the health workers I interviewed during my fieldwork knew about the existence of such strategies and many had never even heard of the term “interculturalidad” before. I suspect that what I found in Atalaya is no different from what is happening in other areas of Peru. Having official documents defining and guiding the implementation of an intercultural approach, does not mean the information is being disseminated effectively or that health authorities know about it and/or assign human and financial resources to implement them.

Before analyzing the strategies proposed by the MoH, I will quote the MoH’s definition of an intercultural approach to health. The MoH’s Health Promotion Model document states that an intercultural approach to health:

> "[I]s one that recognizes the need to develop solidarity and respect as well as competencies and abilities (among health providers) that enables them to recognize the cultural, social, economic and linguistic differences that exist in their relationship with the "other' [i,e. indigenous people]. These differences form the complex stage where health and illness processes are constructed in the Peruvian population" (MINSA 2004:30)[73]

There are two core ideas in this definition. The first is there are "cultural, social and linguistic" differences between health providers and indigenous people. The second is that it falls on health providers to develop values (solidarity and respect) and skills (competencies and abilities) to recognize how illness and health are social constructs and as such vary from group to group. The following sub sections describe the strategies proposed to develop the values and skills necessary for an intercultural approach to health: training health workers to become culturally competent, promoting the articulation of medical systems, and ensuring community participation and community perspectives in health services.

3.2.3.1 TRAINING HEALTH WORKERS TO BECOME CULTURALLY COMPETENT

Based on the MoH's Norm discussed in section 3.2.2, one strategy first proposed to incorporate an intercultural approach to health care has to do with preparing the health workers who provide health services for indigenous people. The strategy consists in training programs that teach health workers about indigenous systems:

[73] [El enfoque intercultural] reivindica la necesidad de desarrollar tanto valores de solidaridad y respeto, como competencias y habilidades (en los prestadores de salud) que permitan reconocer en la relación con "el otro", que son justamente las diferencias culturales, sociales, económicas y lingüísticas las que componen el complejo telón de fondo sobre el cual se construyen los procesos de salud - enfermedad de la población peruana.

> "Incorporating into training programs for health workers, topics on (…) interculturalidad. [Such training programs] will give priority to professionals working in indigenous communities (…). The training will include topics about local culture and local gender systems. They will also receive information about the language spoken by the population who uses the services.[74] (MINSA 2006:33)

Teaching health workers who are to be sent to work among indigenous people about indigenous culture and local language is, for the MoH, one first step to make health workers competent to provide intercultural health services. Other complementary strategies include "Improving the competencies of health workers to conduct a participatory assessment using a gender approach and intercultural dialogue[75]"[76] (MINSA 2006) and putting "mechanisms in place to facilitate the recruitment of health workers from different ethnic groups taking into account their fluency in the local language"[77] (MINSA 2006).

These three strategies targeted at health workers provide training in local cultures and languages, and the training improves the capacity to conduct participatory community assessment through an intercultural dialogue. The MoH also states it would recruit health workers who belong to the ethnic group and speak the local language. The strategies are meant to encourage health workers to become culturally competent to work among indigenous people.

Cultural competence is a concept developed in the U.S. to refer to the skills clinicians ought to develop and put in practice to serve people from different ethnic backgrounds

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[74] Se incorporará en los programas de capacitación al personal, contenidos en derechos humanos, género e interculturalidad, priorizando a aquel personal que trabaja en comunidades indígenas, que inicia su ejercicio profesional, que es rotado y que forma parte de los equipos itinerantes, serán capacitados, en particular, sobre cultura local y los sistemas de género locales. Además se brindará conocimientos sobre lenguas locales de las poblaciones usuarias de los servicios de salud.

[75] Intercultural dialogues is a methodology used by CENSI that will be described in detail in sub section 1.2.3.3

[76] Se desarrollarán competencias del personal (…) para la implementación de diagnósticos participativos con perspectiva de género y de dialogo intercultural.

[77] Se promoverán mecanismos que faciliten la incorporación como trabajadores o trabajadoras de salud a profesionales o técnicos de salud mujeres y varones, de diversos grupos étnicos culturales en atención al manejo de lenguas o idiomas locales.

(Campinha-Bacote 2002). The strategies for cultural competence proposed by the MoH suggest that health workers can be educated about a particular ethnic group as part of a training course. The shortcoming of cultural competence training is the risk of oversimplifying the characteristics of specific indigenous groups, and reducing intercultural health provision to a list of "do's and don'ts" rather than engendering a real change of attitude towards people from different cultural backgrounds (DelVecchio Good 1995).

3.2.3.2 COLLABORATION BETWEEN MEDICAL SPECIALISTS

The second strategy suggested by the MoH urges health workers to go beyond just respect and recognition of indigenous medical systems. The second strategy seeks to harmonize different medical practices and allow for negotiation of medical decisions and prescribed treatments. This strategy draws from PAHO's definition of intercultural health in which it postulates that health providers should not only "recognize and value" indigenous medical practices but also "harmonize and negotiate the differences that exist between different groups in the society" (OPS 2008).

Besides training health workers in indigenous culture and language, the MoH states that health providers need to assume an attitude of mutual learning:

> "Health providers must **respect** the practices and beliefs of the population using health services. **Interaction and mutual learning** with agents of traditional medicine will be promoted thereby promoting **complementarity in service provision,** provided this does not violate human rights or puts the patients' health at risk[78]"(MINSA 2006, emphasis added).

[78] Los proveedores y proveedoras deberán respetar las prácticas y creencias de la población usuaria de los servicios de salud. Así mismo se promoverá la interacción y aprendizaje mutuo con los agentes de la medicina tradicional, promoviendo así la complementariedad en la atención, siempre que no vulneren derechos humanos ni atenten contra la salud.

This strategy suggests that the MoH will somehow promote not only interaction between health workers and agents of traditional medicine (i.e. indigenous healers) but also mutual learning in order for both to complement each other's work when they are providing health services. This idea sounds very good as an expression of an intercultural approach to health, yet the last sentence of this strategy "provided this does not violate human rights or puts the patients' health at risk" can invalidate all the positive in the above suggestions.

The last sentence implies that it ultimately depends on the individual health professional to decide whether the treatment suggested by an indigenous healer is safe or not, and it is up to the health profession to decide whether a patient's decision to follow a particular indigenous treatment puts his/her health at risk. This places the health worker in a position of power to decide if he/she considers it necessary. Thus, if health workers distrust or ignore how indigenous medicine works, they can override a patient's decision. Health workers are legally responsible for what happens to a patient in their health facility.

During my fieldwork I was able to observe an example like the scenario described above. On one of my visits to the Health Center of Oventeni, I asked a midwife whether she allowed pregnant women the option of giving birth in a squatting position as they traditionally do, and as is allowed according to the MoH's regulations discussed above. The midwife said she did not allow this because she did not feel comfortable attending a birth like that. She felt more confident helping a woman who was lying down horizontally while giving birth. This midwife was particularly friendly with the indigenous people she treated, but chose Western medical practices over indigenous ones because she felt comfortable with doing what she had been trained to do. Similarly, in Bolognesi, a *mestizo* health worker was confronted with a patient who had taken a herbal preparation for her urinary tract infection and was very sick. The woman had

a high fever and was in pain. Before administering her the standard antibiotic treatment, he asked her "*Have you been taking anything for the pain before coming?*" and she replied "*Yes doctor, piñón colorado*[79]." The health worker decided not to administer any medication since he did not know the potential negative interaction between both medications and the woman stayed for a day in the health facility receiving serum with no medication.

The call for "complementary work" between two medical traditions as suggested in the documents from the MoH is not an easy strategy to implement. Many health workers only know Western medical treatments and only trust biomedical practices. The two examples described above show how health workers unfamiliar with indigenous medicine would tend to choose Western medicine over indigenous approaches in practice. They usually consider indigenous medicine a risk for the patient.

The CENSI also promotes the articulation of both indigenous and Western medical systems as a core strategy for intercultural health (CENSI 2010). For the CENSI, one key expression of such articulation between medical systems is that there is a "referral and counter-referral" system in place between medical specialists of both medical traditions.

This "referral and counter-referral system" entails that nurses, doctors and midwives will refer a patient to an indigenous healer (or vice versa) if he/she considers that the other person's professional expertise is more appropriate for the patient's health problem. This demonstrates recognition that indigenous medical systems are also capable of providing solutions to health problems. Thus, a more comprehensive definition of intercultural health is not only one where health workers work together with indigenous specialists but one where they defer to a specialist of the other medical system to take care of a patient. For this to happen, health workers must

[79] *Jatropha gossypifolia L. This is a bush with small fruits. For urinary infections, the person has to scrape the bark of the bush and boil it. The patient will then drink the tea and do vaginal douches.*

respect the other medical system and acknowledge its capacity to solve health problems that Western medicine cannot, such as people who have been victims of witchcraft.

3.2.3.3 COMMUNITY PARTICIPATION AND INTERCULTURAL DIALOGUES

The two MoH strategies for attaining an intercultural health approach that are described above (training that teaches health professionals about indigenous culture and motivating health professionals to interact with and learn from indigenous healers) are targeted at health workers: The third strategy is targeted at both health workers and the community and is known as "*Diálogos Interculturales*" or Intercultural Dialogues. Intercultural Dialogues is a methodology developed by CENSI based on the idea that community participation is crucial to providing culturally-appropriate health services.

The goal of intercultural dialogues is to improve health services for indigenous people by adapting to the local demands of indigenous people via a structured dialogue between communities and health workers (CENSI 2010). By "structured dialogue" CENSI means more than just unplanned, informal dialogue. Structured dialogue involves preparatory sessions where the community meets with representatives of CENSI and shares their demands and expectations about health services. At the end of such a meeting a document is drafted, and the communities' expectations are recorded in writing. Later CENSI representatives hold a similar meeting with health workers where they ask the health workers about the challenges they face serving the community they are working in. Finally there is a third meeting where both parties bring their ideas and discuss the changes that can be introduced to improve health service provision (CENSI 2010).

Intercultural Dialogues provide an opportunity for communities to do a joint assessment of the local health problems and develop a plan to improve existing health conditions (INS

2010). The communities are usually represented by traditional healers and community authorities. In the context of the Intercultural Dialogues the community has the opportunity to express their demands and health providers are also given the chance to explain their obligations as state health workers and the limitations of what can be done to change the situation (INS 2010)[80]. Intercultural Dialogues are also meant to achieve a closer relationship between health providers and local communities and to incorporate indigenous medical practices in health services (INS 2010). As a CENSI document states the dialogues encourage understanding of indigenous medical practices:

> "These dialogues bring together and connects traditional medicine, the demands of the people and the State's health system, allowing increased knowledge about traditional medicinal and the understanding of cultural syndromes[81]"(INS 2010)

The Intercultural Dialogues methodology proposed by CENSI tries to address three issues at the root of culturally inappropriate health services. The first issue is the absence of a common vision and understanding of health services. The second issue is the inadequate and distant relationship between most health workers and their indigenous patients. The third and final issue, and health worker's lack of information about indigenous medical knowledge and its potential contribution to the services they provide.

Intercultural Dialogues represent an important strategy proposed by the MoH through CENSI. Unfortunately, so far these have only been implemented through NGOs on a small scale

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[80] For example, in one experience of an Intercultural Dialogue conducted by the NGO Salud Sin Limites in Ayacucho, where I had the opportunity to work in 2012, the project manager told me that indigenous people would request the health facility to open at 7 a.m. rather than at 8 a.m. so that they can go before going to their agricultural land. This was negotiated with health workers who agreed on it. However, when the community requested to have a midwife in the health post, health workers had to explain this was not up to them to decide and that there are regulations about how many people and with what qualifications are staffed in a particular health facility. In this sense, I was told by the NGO team that intercultural dialogues become spaces for the community to learn about the way the health system works so that they do not expect services that are not mandatory.

[81] Estos diálogos permiten el acercamiento y articulación de la medicina tradicional, las demandas de los pobladores y la oferta del Estado, permitiendo la obtención de un mayor conocimiento sobre los recursos medicinales tradicionales y el entendimiento de los síndromes culturales. (p.47)

in Pucallpa and Ayacucho, and in Puno by the CENSI[82]. Intercultural Dialogues follow some of the principles that Fernández Juárez (2004) identifies as core for an intercultural approach, "mutual respect and constant dialogue between providers and indigenous users regarding the quality of the services and the validity and importance of each other's medical knowledge" (p.11). As we will see in the following chapter, some of the principles outlined above are part of the strategies INTs use in their everyday work at health facilities.

Mr. Bedriñana, an NGO worker who facilitated Intercultural Dialogues in Ayacucho in 2011, explained to me in an interview that one of the more complex issues the Intercultural Dialogues have to overcome is the history of discrimination in Peru. It cannot be assumed that a dialogue between health providers and indigenous users is a horizontal one from the start. Health providers stand at one end of powerful symbolic dichotomies vis-à-vis indigenous people: they are urban, professionals, government workers, non-indigenous and as such, are symbolically in a "higher" social position. In the communities I visited throughout my fieldwork, most *mestizo* health workers considered indigenous healers as charlatans, and would feel frustrated to learn people had visited an indigenous healer before bringing a patient to the health facility. Some of the people I interviewed told me that they would not disclose to the doctors that they had been to a healer before coming to the Health Center because they did not want to be scolded. This, as we will see in Chapter 4, did not occur when the health worker was an INT.

Scholars who have studied intercultural communication or intercultural dialogues argue that oftentimes, the conditions and possibilities for that dialogue are not present when "we stand within a history that has alternately marginalized and ignored the knowledge of the powerless" (Flower 2003). In such dialogues, you ask the "powerful" (in this case, health workers) to listen,

[82] Interview to Dr. Oswaldo Salaverry, Director of CENSI, in September 2010.

domesticate and assimilate the principles of indigenous medical knowledge into mainstream Western schemas of healthcare provision (Flower 2003). For Ranganathan (2005) "Providing mere access to information is not enough without providing a framework to understand the new information and integrate it with existing knowledge" (p.3). Intercultural Dialogues are an attempt at solving the mistrust between two sets of cultural approaches to health and healthcare that have been living with their backs turned to each other.

As we will see in the following chapter, procedures within a government health facility follow standard guidelines. In order to implement changes that respond to indigenous people's perception of heath and illness, these guidelines must become flexible. For instance, Dr Neptalí Cueva, former director of CENSI told me in an interview conducted in 2008 that during the 1990s, when he worked at a rural health post in Cusco, he forbade the use of aprons in the facility. He conducted a survey about what people did not like of the health services and it turned out indigenous women did not like health workers wearing white aprons during birth because it frightened the children who were being born. "*My son gets scared… he is entering [the world] and sees that [the white apron and mask] and he goes back*". So, Dr. Cueva told his staff to stop using white aprons and face masks and to begin using a transparent piece of cloth so that the baby will be able to see their face and not get scared. He was reprimanded for that but he believed that if small changes like that can improve health services and should be allowed (Cueva Maza 2008)[83].

[83] Yo he sido sancionado porque en la posta yo decía acá no se usa mandil, qué se usa. Porque hicimos una encuesta, antes del año 90… qué es lo que no le agrada. "A que el mandil blanco asusta a mi hijo, por eso no vengo…" Quítate el mandil. (…) Entraban a atender el parto así (con la mascarilla) (…) Mi hijo se asusta… está entrando y ve eso y se regresa… quitemos eso. Nos quedábamos ya sin nada para aguantar las infecciones, ponte algo transparente pero ya se te veía la cara… o sea: ibas creando. Pero creabas a partir de algo que escuchabas, que no hacías oídos sordos. Porque uno diría "qué zonza, cree que se va a regresar el bebe" pero se hiere la sensibilidad en su forma de pensar ver cómo te vas adaptando. Esas cosas simples si se pudieran hacer en mayor número sería mejor.

Intercultural health approaches – as the previous example shows – require that standard procedures described in governmental guidelines be flexible enough to allow for changes. Intercultural health approaches cannot be guaranteed by only agreements between health workers and indigenous communities about health services. Intercultural health requires flexibility from the health system to introduce changes in both curative and preventive activities.

3.3 CRITIQUES TO STATE SPONSORED INTERCULTURAL HEALTH

As I have presented throughout this chapter, both the PAHO and the MoH understand intercultural health as a model of health care that recognizes and values the different ways of understanding health among different societal groups and promotes harmony and negotiation between indigenous people and non-indigenous urban sectors of the society (OPS 2008). The goal of intercultural health is to improve the existing national healthcare system in order to better serve indigenous populations. One problem with state-sponsored intercultural health is that it has not managed to establish policy-level discussions with indigenous organizations and indigenous perspectives are often missing from the proposed strategies (Ramírez Hita 2011). For instance, none of the MoH strategies presented in this chapter include ways in which state health authorities enable the voices of indigenous organizations to be incorporated in how health services are provided.

Thus, one critique of state-sponsored intercultural health (that is reflected in the Peruvian case) is that there are no clear strategies to engage with indigenous organizations. Except for the Intercultural Dialogues, community participation is not at the core of these policies. Intercultural health strategies are designed and implemented by governments, making them vertical "top-

down" efforts. If channels of communication between regional health authorities and regional indigenous organizations were established, efforts like AIDESEP's in Atalaya – as we will see in the following chapter – would not be just isolated efforts of intercultural health care.

Another critique is that top-down intercultural health efforts focus on the importance of communication, and that focus leads to an oversimplification of the complexity of an intercultural approach. As Ruiz –based on his work on intercultural health in Nicaragua- assessed cultural competence is a complicated notion:

> If the problem is culture and being able to communicate across the cultural divide, then an "add culture and stir" approach is all that is needed. The policy recommendations therefore are limited to adding elements of "cultural competence" to the staff of the health system through workshops and education (Ruiz 2006:197).

As we will see in the following chapter, the implementation of an intercultural approach to health care requires much more than training health workers. Although lack of cultural competence among health professionals is a core criticism by indigenous organizations in Peru such as AIDESEP, the problem is much deeper and broader than it seems. In Chapter 4 – where I present an analysis of INT activities – I will show that there are structural aspects of the health system that limit the possibilities to develop an intercultural approach to health. There is a need to recognize indigenous people as citizens entitled to receive health services that respect and promote their medical practices. Treatments, medical protocols and even health promotion continue to be urban, Western and thus INTs have many challenges to overcome.

Authors who are critical of intercultural health argue that definitions often lack a clear theoretical and operational understanding of the different levels at which an intercultural approach needs to take place (Johnson 2010). Using Albo's ideas about micro and macro interculturalidad (discussed in Chapter 2), it can be argued that there is ambiguity concerning the

levels at which intercultural health ought to occur. For Johnson (2010) there is no clarity about which level the MoH is referring to when discussing intercultural health. Johnson states that a comprehensive intercultural approach would aim to make changes at the level of health services, health policies, medical protocols and of course in the relationship between health workers and the communities they serve. These distinctions are crucial in understanding the limitations faced by INTs in Atalaya.

There is one final criticism of intercultural health made by Ramirez Hita (2009). For this author, it is shortsighted to blame the problems of ill-health on cultural differences. Ramirez Hita (2009) questions whether in Bolivia discussions about intercultural health and the search for complementarity (*complementariedad*) between Western and indigenous medical systems distracts attention from more important and urgent debates about indigenous health. She suggests that discourses on intercultural health in Bolivia have had the effect of shifting the focus of attention to *interculturalidad* and not immediate or serious health needs or other inequalities that indigenous peoples have been subject to in the health sector (Ramírez Hita 2009). Such criticism is not part of the discussions around intercultural health in Peru, but it is worth taking it into consideration. Ramirez Hita warns about the negative impact of a merely political use of intercultural health: concealing broader social determinants of health (poverty, marginalization, exclusion). AIDESEP could learn from such warnings so as not to restrict its arguments to the realm of cultural recognition but also to the rights to have their basic needs addressed.

Ramirez Hita (2009) argues that indigenous people's health conditions are not a result of the State's dismissal of indigenous medical traditions but due to social and economic marginalization. She further claims that intercultural health is often a cheap political and economic strategy to make "visible" changes but ones that ultimately maintain the same

frameworks of marginalization and subaltern status of indigenous groups. Attention is diverted from the need to address the health system's deficiencies in terms of infrastructure, human resources, and allocation of medical supplies (Ramírez Hita 2011).

3.4 SUMMARY

Since the early 2000s, intercultural health is a prominent theme in the Peruvian MoH's efforts to reduce health inequalities among indigenous people. Its strategies have focused primarily on health workers abilities to interact with indigenous people and to collaborate with indigenous healers. Promoting community participation is also part of the strategies proposed. AIDESEP's focus, on the other hand, stresses the importance of having indigenous medical traditions recognized and rescued from the marginal position they have been relegated to over the years.

The Peruvian MoH began its efforts to promote an intercultural approach in the early 2000s through the creation of the Center of Intercultural Health that promoted the creation of policies and norms on intercultural health. CENSI has had no leading role – so far – in the promotion of intercultural health beyond Intercultural Dialogues. However, other offices within the MoH (mainly Health Promotion) issued Technical Norms defining what an intercultural approach to health is and what strategies ought to be followed to implement it.

The strategies suggested in the norm call for training health workers about indigenous culture and language, and the promotion of a learning relationship between indigenous healers and health workers. The idea of having health workers working together with indigenous healers resonates with earlier efforts promoted by the WHO and PAHO to integrate medical systems.

In countries like Bolivia, Guatemala and Ecuador the integration of indigenous healers into the national health systems have been part of broader intercultural health efforts (Castañeda, García Barrios et al. 1996; Maupin 2008; Ramírez Hita 2010). However, critiques of such approaches indicate that despite the efforts, health professionals still do not see indigenous healers as "equals", that staffing health facilities with indigenous healers is an artificial strategy targeted at bringing indigenous people into the national health system rather than recognizing the inputs of indigenous healers as valuable.

Another crucial critique of intercultural health efforts is that they focus on the micro level. Intercultural health efforts concentrate on the interactions between health workers and indigenous patients, the interactions between health workers and indigenous healers and strive to improve the capacity of both groups to communicate with each other, thus ignoring the need for broader changes. This will become evident in Chapter 4, where INTs efforts at the micro level do not have an impact on broader changes in the health system, nor are there established avenues to do so.

By focusing on the lower micro levels at which intercultural health can occur (the health facility, community activities), the MoH overlooks that changes are also required at the level of the health system. It is necessary to also set health priorities, make medical protocols more flexible, and provide the legal framework to allow the use of medicinal plants at health facilities. As I will show in the following chapter, as long as the health system remains a monolithic entity based on Western medical premises, the possibility of transforming the health services so that indigenous medical principles are accepted as good and right remains elusive. Furthermore, intercultural approaches that do not question broader structures imply that long-standing

hierarchical relations between indigenous culture and the national culture (that indigenous organizations such as AIDESEP want to change) will remain intact.

The MoH might have set the basis for changing certain aspects of health care provision for indigenous people through norms, regulations and definitions but it has not managed to move beyond those limited parameters. As we will see in Chapter 4, there are a number of challenges faced by INTs when working within governmental health facilities.

4.0 AIDESEP'S INTERCULTURAL NURSE TECHNICIANS' INTERCULTURAL HEALTH EFFORTS

Despite the MoH's official position promoting an intercultural approach to health as a means to improve the quality of services for indigenous populations, neither INT's nor health workers in the health facilities I visited were aware of such position. M*estizo* health workers (unlike indigenous INTs) were not even familiar with the term "intercultural health" (*salud intercultural*) and in our conversations they would often guess it was about having health workers who spoke the local indigenous language. INTs on the other hand considered that a core element in any intercultural health effort was the respect and use of indigenous medicine.

As I will show in this chapter, intercultural health efforts implemented by INTs entailed much more than speaking the same language as patients. Despite INTs training in both medical systems, which formed the basis of their intercultural education, INTs lacked clear guidelines about what AIDESEP expected them to do once finished their training and began working at a governmental health facility. How and when were the INTs supposed to use such an approach?

Throughout their training, they had been encouraged to promote indigenous medicine and use indigenous medicine techniques in health care provision. They were taught to feel proud of their indigenous heritage. However, once INTs entered the workforce where the guidelines are based on biomedical protocols, the provision of intercultural health services was difficult. The INTs had to be creative and make an effort in their own daily routines and in the scope of their

interactions with patients. There was no explicit support for using an intercultural health approach in the existing government protocols of primary health care.

In this chapter I present several examples of how INTs implemented an intercultural approach in the services they provided at government health facilities. Most of the examples I collected during my fieldwork had to do with one core aspect of intercultural health; INTs were promoting the respectful, collaborative use of two medical systems to address the health needs of the population. I also collected examples of other aspects of intercultural health, such as how INTs engaged in close interaction with community members to better understand their health needs and assure that health services were sensitive to cultural traditions.

Cross-fertilization between indigenous and non-indigenous medical systems had been occurring in several areas of the Amazon for a long time. Indigenous groups would take elements from one medical system and elements from another and/or combine biomedical and indigenous explanations for disease (Pollock 1996; Roseman 1996; Foller 2002)[84]. Most indigenous groups have also experienced the contempt of non-indigenous people towards their medical practices (Wayland 2003). There is, however, some recognition from health authorities that indigenous medical practices do play a role in maintaining the health of indigenous populations (Pollock 1996). This chapter addresses what happens when the ability to move among medical systems and understandings of disease becomes part of health services.

The use of indigenous medicine and indigenous practices within health facilities have been described in other intercultural health efforts in Latin America (Almaguer González, Vargas Vite et al. 2003; Alvarez Diaz 2005; Hale Gallardo 2006; Ramírez Hita 2011). Most of

[84] For example, Pollock (1996) found that his Kulina informants speculated that the reason why local Brazilians suffered high rates of infant mortality, was because "non-Kulina were not aware of the food prohibitions that new parents must obey. Brazilian infants, in other words, are assumed to be dying of epetuka'i , an illness that Kulina understand and know how to cure" (p.337).

the intercultural health elements used in health facilities have been one of the following: the use of indigenous language by health workers, the participation of indigenous healers at the health services and the use of medicinal plants (Ticona and Duran 2009). This is also true for some of the examples I collected from INTs; however, there are also other ways the INTs combined indigenous and Western medicine in primary health care. These practices are grounded in a characteristic unique to the INTs. The INTs can use indigenous medicine (albeit not to the degree of a specialized shaman) and Western medicine equally.

This chapter describes the efforts of Hugo, Javier, Servando, Norberto, Imelda, Ernesto, Mario and Oscar. They are eight[85] INTs working in governmental health facilities in the districts of Sepahua, Tahuanía and Raymondi in the province of Atalaya. I will specifically address those instances where the INTs were able to use both indigenous and Western medicine (alternately or in combination) to serve the indigenous population. I will discuss the opportunities and the challenges the health system posed to such efforts.

INTs were working in underserved indigenous areas where they had to make decisions in regards to patient well-being using medical principles, treatments and drugs from both medical traditions. The INT's work shows that applying an intercultural approach to health is not about following "recipes" or static, formal guidelines for intercultural health. The INTs have found that their efforts require adaptability and creativity when dealing with the local conditions.

I have organized the examples of intercultural health services based on the type of health facility where the INTs worked. The INTs worked at either Health Posts (*Postas de Salud)* or Health Centers (*Centros de Salud*). The INTS had to adjust their services depending on the types of facilities were they worked. The type of facility had an impact on what kind of practices they

[85] Six INTS were observed in situ and two others were interviewed on their experiences working at a governmental health facility.

used and how much flexibility they had to adapt the services to local cultural characteristics. The first section will describe the experiences of Hugo, Javier and Servando at Health Posts where they were the only health worker in charge of providing health care. The second section will describe the experiences of Imelda and Norberto working at a Health Center where they were part of a larger medical team. I complement this second section with information from interviews with two other INTs, named Oscar and Ernesto. Oscar and Ernesto had also worked at a Health Center and provided more examples about the intercultural health efforts employed by INTs.

Table 10. INTs visited per type of health facility per district

TYPE OF HEALTH FACILITY		DISTRICT			TOTAL PER SCENARIO
		Sepahua	Tahuania	Raimondi	
Health Center	Own ethnic group		Ernesto[86]	Imelda	1
	Different ethnic group		Norberto	Mario	2
Health Post	Own ethnic group		Servando	Oscar♦	1
	Different ethnic group	Hugo & Javier			2
TOTAL per district		**2**	**2**	**2**	**6**

4.1 INTERCULTURAL EFFORTS AT A HEALTH POST

This section describes the experiences of Hugo, Javier and Servando, three INTs working at a Health Post in the indigenous communities of Shari, Nariteri and Shipaya. The efforts of each of these INTs to use an intercultural approach are similar but also particular to the context in which they worked. Their efforts are also particular to the characteristics of the indigenous group they worked for. Their experiences show that one core element of intercultural health is to

[86] Only interviewed, not observed in situ.

be flexible and resourceful when addressing the health needs of the local population. INTs have to adapt to the circumstances they work in.

Hugo and Javier worked with an indigenous group different from their own. Both Hugo and Javier belonged to the Yine ethnic group[87] but Hugo was working among the Nahuas and Javier with the Asháninkas. These groups not only spoke a different language but also had a different medical system than the Yine. Their experiences are interesting because they show that knowing the language is not necessarily the core element to provide intercultural health services. Rather, enabling people to use their own medical traditions at the health post or being open to work side by side with the local indigenous healers were more fundamental.

Servando, unlike Hugo and Javier, worked among his own ethnic group, the Shipibo-Conibo. As we will see in the following sections, these three INTs developed different strategies that, at their core, follow three important components for an intercultural approach: respectful collaboration between medical systems, horizontal relationship with the community served and capacity to adapt to local conditions.

4.1.1 HUGO AMONG THE NAHUAS

When I visited Hugo in October 2010, he had been working among the Nahuas for over a year. Hugo was working at Shari, a small settlement of around 39 families. Hugo and I began our

[87] Yines belong to the Arawak linguistic family and have been known in Peru as "Piros." According to Hugo, Piro is the name of a small fish his Yine ancestors used to consume frequently but that nowadays is not so easy to get. He guesses that probably when the missionaries arrived to the first Yine communities they heard the word a lot and that is why they called them "Piros" (Smith Bisso, 2003). Alejandro Smith explains that the word "Piro" is not an Arawak term but rather one that comes from the Pano linguistic family. The term "Yine" is a word that means "humanity" or "the human condition" and thus, as many other indigenous groups from the Amazon, they have managed to contest the term that missionaries and later anthropologists used to refer to them and demand people to use the term they use to refer to themselves. The Yines are a small indigenous group; according to the 2007 National Census of Indigenous Communities in the Peruvian Amazon[87], there are 3,261 Yines in Peru (Gonzales Quiroz, 2010)

trip to Shari together from Atalaya where he had travelled to vote in the municipal elections that year. To arrive at Shari we travelled from Atalaya by boat upstream to Sepahua, seven hours upstream on the Urubamba River by public fluvial transportation[88]. We stayed a couple of days in Sepahua waiting for the head of the Health Center (who was away on a business trip) to sign a credit note for the local gas station that would provide Hugo with the necessary gasoline for a roundtrip from Sepahua-Shari-Sepahua. Hugo also needed a three-month supply of medications. People at the Health Center in Sepahua asked him to wait a few days until medications arrived from Atalaya. While in Sepahua we bought the food supplies not available in Shari (where there is only yuca, plantain and fish). We bought mostly non-perishable goods such as canned food and noodles, also rice and some vegetables.

From Sepahua we traveled six hours upstream on the Serjali River in a canoe[89]. Hugo was the first health worker to work permanently in Shari. The Health Post had been inaugurated the year before. It was made out of concrete and had four rooms, a space for a pharmacy and two bathrooms. According to the mayor of Sepahua, the health post in Shari was too big for the population it served; however, the previous mayor built it as a political statement to show his concern for indigenous people.

When I arrived at Shari I was interested in learning not only about Hugo's efforts to provide intercultural health but also people's use of indigenous medicinal plants and the work of traditional healers. In Shari, as explained in Chapter 1, I was told that Nahuas preferred Western

[88] There are three boats that provide fluvial transportation service from Atalaya to Sepahua three times a week (Mondays, Wednesdays and Fridays) in "passenger boats" (*bote de pasajeros*) which are big boats that fit around 25 people

[89] It took us six hours because we used a 35 hp engine; most people have a peque peque which is a simple engine (16 hp) attached to a small boat- Going from Sepahua to Shari would have taken us up to twelve hours with the smaller motor. The canoe belonged to Hugo, but the 35 hp engine was a donation to the Nahua community from the gas company in the area. Nobody in Shari knew how to maneuver it and so it was given to Hugo so that he could use it to evacuate patients, get medical supplies and travel to Sepahua when necessary.

over indigenous medicine. Furthermore, some older Nahuas told me that very few people were interested in learning about indigenous medicine. However, during my stay in Shari I saw people from the community requesting healing services from the community's *Jefe* (chief) on more than one occasion. The community's *Jefe* was also a shaman. I also observed local people using medicinal plants, as I will describe in detail later in the chapter.

During my first conversations with community members regarding Hugo, I learned that people in Shari were aware Hugo was an INT, trained in both medical traditions. The community members told me that when he first arrived, Hugo informed the community in a meeting about his intercultural training. I confirmed this with Hugo later.

Having someone like Hugo in the community (someone able to use both types of medical traditions) was considered of great importance to some people. Oftentimes, there were not enough medications at the Health Post and Hugo had to resort to the use of medicinal plants. One informant (Luis) assessed that a health worker who does not know how to use indigenous medicine would not be of much help in Shari. Furthermore, Luis appreciated that Hugo was also an indigenous person, concerned about the community's problems:

> "*If a mestizo person comes, it has to be a mestizo that is worried about our people, who will be requesting medications together with the people. He has to work together with the community. What I have liked most [about Hugo] is that he has organized a soccer tournament and has taught young people how to play sports. He has also shown interest in helping the Nahuas. For instance, when INDEPA came [National Institute for Indigenous People] he helped us because he is also indigenous and he has the right to speak for us. He feels like an indigenous person because as indigenous people we ought to help each other. He is an example for the community.* [90]**"** (Luis, Shari, October 2010)

[90] Si viene un mestizo, tiene que ser un mestizo que se preocupe por el pueblo, que solicite medicamentos, que se preocupe que junto con el pueblo pida medicamentos., para que trabaje junto con la comunidad.
Las cosas de que más me ha gustado es que ha organizado el torneo de futbol, enseño deporte a los jóvenes, hizo un campeonato y se preocupó por ayudar a los pueblos Nahua. Por ejemplo cuando llegó INDEPA de Lima, él los ayudó a que hablen porque él también es indígena y tiene derecho a hablar por nosotros. El siente como nativo, porque entre los indígenas nos tenemos que ayudar. También es un ejemplo para la comunidad.

This statement has two important points regarding the expectations that the Nahuas have of someone who comes to work in their community. On the one hand, the Nahuas appreciate when the person who works there gets involved with the community's problems and participates in the community beyond the provision of health care. Many told me how grateful they were that Hugo had taught them to play soccer[91], and that he organized soccer matches during the weekends for women and for men. Once he also organized a match for older people which everybody remembered very fondly. Hugo got involved in other community matters and tried to assist the Nahuas with some problems, such as when the Gas Company made promises but did not deliver. Hugo even spoke on behalf of Shari when a government commission came to supervise the natural reserve in which the Nahuas live.

During several informal conversations, the women from Shari told me they liked Hugo because he visited them in their homes. He would tell jokes all the time (mostly teasing people and calling them funny names) and he would also let people come and hang out in the health Post. Sometimes when there was gasoline available, he would activate the generator to play movies in his own TV during the night (7p.m. - 9p.m.) and most people would come and gather at the Health Post to enjoy a moment of entertainment.

Hugo would open the health post at 7 a.m. every day. He would start sweeping and organizing the benches for the patients. By the time he was done, there would be at least five mothers with their children asking for an injection, or some cough syrup or for their baby to be nebulized because of respiratory problems[92]. Hugo would patiently see each of the cases, but would not always comply with the request to give children shots. As I realized after several

[91]Hugo brought a DVD with several soccer matches where they analyzed the techniques of famous soccer players
[92] To understand the great concern of mothers regarding respiratory illnesses one needs to remember that in the early 1990s many Nahuas died because of these ailments upon being contacted by loggers.

weeks in Shari (and then in other indigenous communities), indigenous people visited the health facility mostly to get injections and/or pills.

I was surprised by how much people in Shari knew about different antibiotics, anti-parasitic and fever-reducing pills. They would often go to the Health Post and ask for a specific medication (as if it was a pharmacy) rather than requesting a diagnosis and then receive a treatment accordingly. This sometimes upset Hugo and other INTs and *mestizo* health workers I spoke with. They felt community people were –in a way – overlooking their training as nurse technicians. Besides, this put them in a difficult position as health workers because oftentimes people wanted an antibiotic when the health worker did not consider that was the treatment needed. They would have to explain to people why they could not administer antibiotics "on demand" which oftentimes made people feel frustrated.

Hugo for example, told me that sometimes he would refuse to administer an antibiotic to a baby because he knew it was not good to give too many antibiotic shots to babies. He would then learn that people went behind his back and asked the health promoter[93] from Shari to give an antibiotic shot to the baby. Some people in the community bought antibiotics in Sepahua (when they travelled there) and kept them at home for whenever they needed it. Others would not finish taking the whole treatment of pills and would keep some for another occasion.

Besides antibiotics, people in Shari would request Hugo to administer them saline (*suero*) intravenously whenever they had an intense stomachache. Such treatment, Hugo explained, was supposed to be used for people who were dehydrated as a result of diarrhea and vomiting. Nahuas in Shari had learned that people with stomachaches and diarrhea will receive saline intravenously and whenever they had a stomachache (even though they did not have diarrhea),

[93] A person from the community with some basic training in PHC

they would ask Hugo for it. If he failed to do so, people would get upset. While I was in Shari, I saw Hugo connecting the saline intravenously to people who came to the Health Post with intense pain in the stomach. He had to be careful about this practice since his supply of saline was limited and he had to always to save at least two liters for any real emergency.

Hugo knew everybody in the community by name. He would be often invited to have some *chapo*[94] or share food in people's homes. People were constantly joking with him and he was invited to participate in the community meetings and asked for advice regarding community issues. For me, this was an example of his good relationship with people in Shari, and a good basis for intercultural health. When I asked Hugo about whether or not he was using medicinal plants to treat people, he told me that in the past year he had used medicinal plants to treat fever and cough. It was not until my second week there that I began to see examples of intercultural health efforts for myself. For example, I saw the use of medicinal plants within the Health Post. However, what was different from the examples in the literature was that it was not about an indigenous healer practicing indigenous medicine at the health facility but rather about the health professional (Hugo) allowing people to use medicinal plants at the health facility. As I noted in my field notes during one case of serious illness:

> It was hardly six in the morning when Hugo and I were awaken by intense door knocks. "My mom is dying! My mom is dying! Open the door!" Three young men were carrying their mother in arms. They explained that she started throwing up and losing consciousness during the night and that they waited until the morning to bring her to the Health Post.
> Hugo put her in a bed and connected an intravenous device to apply saline since, he explained, it seemed she was dehydrated. After he stabilized her condition, a little girl appeared carrying a blanket and a big pot where some medicinal plants have been boiled. The woman's daughter came a while later with some chunks of cotton. She sat at her mother's bedside, soaked the cotton in the liquid and applied it with a little bit of pressure on her mother's belly. She explained that the *emplasto* will ease her mother's abdominal pain. When Hugo entered the room to check on the patient, the daughter continued with

[94] Beverage made out of mashed boiled ripe plantain mixed with water.

> the indigenous treatment. She then asked Hugo if it was possible to give her some *chapo*, and he replied that she could as long as it was hot; any cold beverage could worsen her condition he assessed (Shari, October 2010).

This situation was interesting for me and I recorded it in my field notes as an example where both medical traditions acted together in the context of the health facility. The most relevant aspect was that this Nahua family (and others throughout my fieldwork) felt comfortable using indigenous medical plants (or other indigenous treatments) to complement the biomedical treatment applied at the health facility by the INT.

It was also interesting to learn that Hugo – as I later confirmed in a conversation – did not see a problem with people using medicinal plants at the health facility, which is one aspect of intercultural health care. Hugo's advice to avoid cold beverages is based on Amazonian medical principles which suggests that certain treatments or ailments "leave a patient susceptible to harm from hot or cold environmental influences" (Jerningan 2011:6). This is related to the concept of diet restrictions among Amazonian indigenous groups because "some foods and activities can exacerbate an illness (…), and some healing plants possess spirits that require the patient to avoid certain foods or activities (…) to prevent conflicting with the treatment." (Jerningan 2011:6)

Hugo's acceptance of people using indigenous treatments at government health facilities while he used a biomedical treatment was an example of an intercultural approach. The scenario is a biomedical facility (the Health Post) but the treatment provided was a combination of two medical systems where neither of them was seen as conflicting. While I stayed in Shari I collected different examples of such combinations (Western and indigenous medicine)[95]. In the

[95] For example, one of the women in the community told me that when her child had a fever she will go to the health post to get some Paracetamol and she will give it to him together with a herbal tea made out of "uña de gato".

previous example, the treatment was prepared and applied by the patient's family; however, in other cases I witnessed the patient's relatives sending for an indigenous healer to provide the treatment at the health facility. There were also instances in which the INT himself (Hugo) applied an indigenous treatment at the health facility as explained in the passage below:

> Yesterday, as we were about to have dinner there was a huge commotion in the community. People were shouting, some women were lamenting and crying and Pedro was carrying Doña Ernestina in his arms. She seemed to have lost consciousness since her body was limp. I asked what happened, and her daughter, in tears, explained her mother had seen the "*tunche*" while washing clothes alone in the river. "*Tunche*" is the local name for the devil[96]. People told me that you recognize or feel its presence usually when you are alone. He calls for your attention either through a whistle or by teasing you (throwing things such as pebbles, bananas or other fruits)
>
> As people placed Doña Ernestina in a bed while crying and lamenting about her condition, Hugo went to his bedroom in search for tobacco. He asked everybody except her close relatives to leave the room. It was dark and he did not have time to turn on the generator that provides electricity to the health post in case of an emergency. He started singing in Yine (his mother tongue) and then lit the tobacco and proceeded to suck in different parts of Doña Ernestina's body. He explained later he was sucking the negative energy Doña Ernestina had inside her because of the *tunche*. After sucking in her belly and head Hugo began to throw up, and kept exclaiming "*esto está fuerte*", which meant that the damage caused by the *tunche* was strong and was not easy to get rid of. After he was done, the old lady regained some consciousness (Shari, September 2010).

The family of Doña Ernestina was grateful that Hugo had tried to suck the *tunche* from her. Later in the night, the shaman of the community came and did the same thing, only he did not sing. It was a silent ceremony. The following day, Doña Ernestina was feeling better and went home.

Similarly, an old guy who knew how to heal a cold by blowing tobacco, will also recommend patients to get a shot at the Health Post.

[96] The tunche is the local name use to refer to an evil Amazonian spirit; it is a mythological being that wanders around in the dark nights. As Steward (1950) explains: "There is a universal belief in bush spirits, (…) which some tribes thought of as debased human beings, others as semisupernatural creatures who roam the bush seeking to torture and annoy unwary human beings. They stupefy and torture their victims by supernatural means and are everywhere feared." (p. 856).

As an INT Hugo was prepared to face illnesses that were not part of the biomedical realm. He did not question people's diagnosis that Doña Ernestina had in fact seen the *tunche*, as he went straight to the room where he kept his tobacco and began the treatment. Most importantly, people trusted he could do something and that is why they brought Doña Ernestina to the health post. Seeing the *tunche* – they explained to me later – can have deadly consequences so it is important to act fast.

Besides using indigenous medicine at the health facility, intercultural health also took the shape of performing healing rituals associated with traditional medicine even while using allopathic medicine. Hugo, for instance, told me that in complicated cases (such as when the patient is about to die) he would resort to singing to the medication before administering it, asking the medication to heal the patient. He explained that during his training in Atalaya, the shaman taught him that when treating a patient with indigenous medicine one sings to the plant asking it to help in healing the patient; other times one sings to the "mother" of the illness (which can be an animal) and ask her to leave the patient alone. This practice is common among Amazonian shamans who use ayahuasca to heal (Beyer 2009). Hugo applied these ideas and rituals to strengthen the power of the Western medications he administered at Shari.

I realized that a key condition for Hugo applying an intercultural approach in his treatments was that he shared similar ideas about the body's internal structure and vulnerability to illness as the Nahuas. Throughout my fieldwork for instance, I overheard conversations where people told stories about someone who had suffered from *cutipa*[97].

[97] Cutipa is an Amazonian concept that refers to something that penetrates one's body, and causes harm or uneasiness (malestar) (OPS 2008). Cutipa is also linked to the idea that the qualities of animals can be passed on to a person when eaten or seen. Belaúnde (2001) found that among the Piro, women who are menstruating had to avoid certain types of food. They are encouraged to eat "soft" foods such as ripe plantains and boiled corn; they are also

There are multiple reasons why someone can become *cutipado*. Among the reasons for *cutipado* are parents not following specific dietary restrictions when their child is still a baby, consuming certain plants or animals or even seeing certain animals (Dávila Herrera 2006). For example, when León (2011) was conducting fieldwork among the Tikuna in the Colombian Amazon, a child died. Local people explained that the child's death was a result of him having been *cutipado* by the "mother" (*madre*) or owner ("*dueño*") of the Catagua tree (*Hura crepitans L*). Before the child became sick, his father had cut several Catagua trees without asking permission from the "Catagua's mother" to do so. Even touching a Catagua tree that has been cut and is lying on the ground can "*cutipar*", people told León (2011).

During my stay in Shari, I witnessed Hugo reminding mothers of small children about the dietary restrictions they had to follow to prevent the child from falling sick. People also discussed with Hugo why someone had fallen sick, using indigenous explanations of disease causation, such as not following dietary restrictions before going on a hunting expedition. Hugo himself had to stop playing soccer on a regular basis because his three-month old daughter became *cutipada* with the soccer ball[98].

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fed meat from small animals and small fish that do not have much blood. They must avoid eating big animals such as the sachavaca (tapirus terrestris) or the huangana (tayassu pecari) that may cause a hemorrhage.

[98] The Nahuas, among which Hugo worked, did not know how to play soccer so he taught them with videos he brought, screening them in a small TV borrowed from the school teachers and using the health post's generator. He organized championships and played soccer every day of the week after closing the Health Post. One day his daughter got sick, with diarrhea and a swollen belly. After trying to cure her with pills, his wife decided to take the child to an indigenous healer in Atalaya. The healer diagnosed the child as "*cutipada*" and healed her by washing Hugo's soccer ball in a plastic tub and then bathing the baby in the same water. The baby's belly immediately decreased in size and the diarrhea stopped. When Hugo returned to the community and people asked him to join them in the evening soccer game he had to refuse. He explained that he could not play for two months to prevent his daughter to get *cutipada*. People in the community understood what that meant and stopped asking him to join them for soccer matches.

While in Shari and in other communities I observed several occasions in which people told the INT that a child was *cutipado* or had *mal aire*[99]. This happened in informal conversations outside the Health Post and not as part of a medical consultation. People were comfortable using local health categories to explain to Hugo (and other INTs as we will see in the following sections) about an indigenous ailment they were either experiencing at present or had in the past. Hugo, as well as other INTs, were also accommodating towards the preferred birthing practices of local people, which included in the case of the Nahuas giving birth only with the presence of their husband.

Once, however, a woman in Shari had complications during her birth and Hugo was not informed until after she had been trying to give birth for almost 24 hours. The mother survived but the baby died. After that episode, Hugo organized a meeting with everybody at Shari to explain that he understood they had their own way of giving birth and that they might feel ashamed of a man who is not their husband being present but that his responsibility as a health worker was to take care of their health. Women in the community agreed to let him know as soon as a mother's contraction began, so that he was ready to provide medical help if things did not go well.

This last example shows that Hugo had been able to develop a close relationship with the community. It also shows that he could explain his role as a health worker and negotiate with them in a way where he could comply with his job requirements (attending births using a biomedical approach) and at the same time respect the privacy Nahuas wanted in those moments.

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[99] *Mal aire* refers to the harmful effects of being exposed to night air that is cold and damp. It is often felt to be caused by moving rapidly from a warm or hot environment into a very cold one, breathing in cold night air, or working up a sweat and not allowing enough time to cool down. The clinical manifestation of mal aire are cold or flu-like symptoms, Headaches, Cramps, Stiff neck, Nausea, vomiting, Fever, Dizziness, Earache, Facial paralysis, Twitching of facial muscles (Greifeld, K., 2004).

Of course, after the meeting, there were still women who would not inform him as soon as they began feeling contractions, but there was always somebody in the community that upon learning about it would let him know. Most of the time his presence was not necessary, but he felt at ease being ready for an obstetric emergency.

4.1.2 JAVIER AMONG THE ASHÁNINKAS

Javier, like Hugo, was a Yine working among another ethnic group. Javier worked among the Asháninkas in an isolated community called Nariteri,[100] on the river Sepa. Nariteri was two days away by canoe from Atalaya and at a similar distance from Sepahua. The main difficulty of reaching Nariteri was not so much the distance but that the Sepa river is not very deep and only small canoes can transverse it. During the rainy season some larger boats might be able to reach Nariteri but, if there was an emergency and Javier had to evacuate a patient, usually he would have to take the patient half way in a canoe until where the fluvial ambulance could navigate.

For Javier, the biggest challenge was not working with a different indigenous group whose language he did not speak. Rather, his most important challenge was that people were not used to having a health worker permanently assigned in the community and felt "ashamed" of stopping by his house to ask him for help. As I described in Chapter 1, Nariteri's Health Post was not finished by the time I was there and during the two years Javier had been working in Nariteri. He kept some medications in his house and others in the community house (*local comunal*)[101], which had a locked storage space for him.

[100] See Chapter 1 for a description of the community.
[101] The Local Comunal is a big house built by the community to hold their assemblies, celebrations or other events such as immunization campaigns.

Lack of medications was a common problem in all field sites, and according to health authorities it was a problem at the regional level. Lack of medications was made worse by the isolation of some communities, where no public transportation services exist and which implies that health workers themselves must travel to the nearest town to collect the allotted medical supplies. Javier told me that on several occasions, medications for his Health Post were not available while he was in Sepahua (major town), so he had to leave without them. However, by the time he returned to Nariteri he was informed they had arrived just after he left town. Unfortunately, he could not go back to Sepahua to pick them up (given the length of the trip and the cost of the gasoline) so he had to figure how to provide health care with a very limited amount of medications and medical supplies.

One of the impacts of the limited availability of medications was that some INTs such as Javier and Hugo resorted to indigenous medicine for health problems. For example, Javier used anti-hemorrhagic plants to contain a woman's intense bleeding after a baby's birth. Javier (from his training as an INT) knew there were Western medications for hemorrhage but he did not have them in stock and, since he knew *sangre de grado* (*Crotom lechleri*) was also effective and readily available, he used plants to stop the hemorrhage. Similarly, Hugo told me that he had used *paico* (*Chenopodium ambrosioides*) in Shari to reduce the fever of several children that had fallen sick in the community when he had run out of Paracetamol.

Besides using indigenous medicine to heal ailments that could also be healed with a biomedical treatment, Javier (like Hugo) combined indigenous and biomedical procedures to treat patients. Once, Javier had to treat a snake bite for Don José (a man from Nariteri). His wife came looking for Javier and took him to his house where Don José was lying in pain. Javier brought anti-venom serum with him (provided by the MoH) and applied it immediately. After

the anti-venom acted, Don José complained of having a headache so Javier prepared some *piri piri*[102] for snakebite and gave it to the patient to drink. Later, at the request of Don José's family, Javier forbid people from the community to enter the patient's house since the patient was weak.

For indigenous people in the Amazon a person who has been bitten by a snake has to "diet". In Nariteri, this meant that he or she should not see anybody who had sexual intercourse the previous day, or a pregnant woman. It was explained that pregnant women and people who have had sexual intercourse can cause the venom to be reactivated and kill the patient. In Oventeni (another field site), restrictions for people who have been bitten by a snake include avoiding any kind of meat for a year. Javier was familiar with the importance of these restrictions and reminded everyone that they should avoid visiting Don José. Besides this case of snakebite, Javier also combined both medical traditions when treating open wounds. He told me he knew of a *piri piri* that was effective in accelerating the development of scar tissue. Whenever anybody needed stitches to treat a deep wound, he would first give the stitches and then apply the *piri piri*.

In Nariteri, there was a woman, Doña Berta, who knew how to heal people with vapor treatments and with massages; she was also the community's midwife. The specific terms for her medical skills were *vaporadora* and *sobadora*. Javier met Doña Berta during a birth in the community:

> *I had just arrived, as a new person, and when you are just finishing your studies you do not have a lot of practice in helping women giving birth and things like that. So I asked*

[102] Piri piri is the generic term used to refer to a medicinal plant. During my field work people will talk about medicinal plants as "piri piri". Thus they will show you a plant and tell you that piri piri is to heal a cold, this other one is for snake bite, or that piri piri help woman be more fertile, etc.

[in the community] where is the midwife?, so that she can help me and I can learn from her[103].

Javier not only looked at a midwife as somebody with whom he could work side by side and who could support his work but also as somebody he could learn from. This is one of the actions that the MoH states it will promote according to its guidelines on intercultural health: "Interaction and mutual learning with agents of traditional medicine will be promoted thereby promoting complementarity in service provision…"(MINSA 2006). INTs were actively doing this.

By the time I arrived at Nariteri I was able to witness the close relationship Javier had developed with Doña Berta. I had been three weeks in Nariteri and Javier decided to visit a woman who was in her last month of pregnancy. By the time we arrived, the woman was having contractions on a regular basis. Doña Berta had been called by the woman's husband, and as she arrived. She told the woman's sisters to prepare the fire so that she could boil some medicinal plants for the woman in labor.

As the plants boiled, the pregnant woman was standing in a semi squatting position supporting herself on a structure made out of wooden sticks. Doña Berta began to give the woman massages on her belly and lower back to ease her pain and accelerate the birthing process. After the baby was born, Javier cut the umbilical cord with disinfected instruments he had brought. He then followed the MoH's protocol of waiting fifteen minutes for the placenta to come out (if it does not come within fifteen minutes he has to remove it manually to prevent a hemorrhage). In the meantime, he sent two children to his house and asked them to bring the

[103] Eso justamente, ella por ejemplo la conocí cuando había un parto. Yo había venido pues como nuevo entonces cuando estas haciendo practicas y estas saliendo recién de estudiar no tienes muchas practicas en cosas de parto y eso. Entonces yo me he ido preguntando dónde hay una partera para que me trate de apoyar y yo pueda aprender.

scale with which he weighed the baby, recording its weight and height on an official form. We stayed there until the mother of the newborn started nursing the baby. Javier wanted to make sure she could breastfeed the baby properly. Doña Berta gave the woman some of the medicinal liquid she had boiled to help the woman recover her strength after childbirth and help the uterus contract.

This birth was for me the quintessential example of an intercultural health approach to birth. It was not in a health facility but rather at the woman's house, in the presence of a midwife who played the key role in helping the mother. Javier did not interfere or question any of the decisions the midwife made but followed the biomedical protocol in regards to receiving the baby and cutting the umbilical cord using surgical gloves and sterilized tools and handling the placenta. Javier told me this had not been the first time he and Doña Berta worked together to help a patient.

In other occasions, Javier requested the help of Doña Berta when the biomedical treatment he had used was not successful. As he explained…

> *"sometimes pills just won't listen"*[104] *so I will go to Doña Berta and ask her "can you do me a service? Do you think you can use vapor with this person?" and she will agree. Other times, I will send people to go and see her, when I realize I cannot heal the person, and they will tell me "No, Doña Berta is going to charge me and I don't have money" So I will go before and ask Doña Berta if she could please see a patient for free and she will accept."*[105]

The relationship between Javier and Doña Berta was very close and they worked together frequently. Sometimes a patient would go to her house and she was aware that Javier had prescribed a pill to this patient. Doña Berta would ask Javier if it was safe to administer a

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[104] This expression is interesting because it implies that pills have the same agency as medicinal plants. This means that for them to be effective you have to request them to ask on an ailment.

[105] y ahora (…) las pastillas ya no hacen caso. entonces voy y le digo "Doña Berta, un servicio, no sé si le puedes vaporar" "si, si." y las personas me dicen "no, me va a cobrar caro" "no, no te va a cobrar, ahora se va a poner buena, gratis te va a hacer el trabajito."

medicinal plant in the form of tea, or perform a vapor treatment. Once, a mother brought her sick baby to Javier. He realized the baby had *mal aire* and referred her to Doña Berta. However, he asked Doña Berta to wait until the child no longer had a fever before treating her with vapor. He was concerned that exposing the child to hot vapor while the baby was having a fever might make the fever rise.

People in Nariteri were open to share with Javier whether or not they had visited Doña Bertha or taken a medicinal plant before coming to see him. Javier's familiarity with the way people at Nariteri used the different medical resources made them comfortable discussing their medical decisions with him. Javier would not challenge the person's medical decision-making process, or scold them for not coming first to see him (as I saw *mestizo* health workers do in Bolognesi). Like Hugo, it was an advantage for Javier to be acquainted with Amazonian understandings of illnesses and of everyday life in the community.

Javier believed that because he was also indigenous he was able to adapt better to live in an indigenous community. This allowed him to promote health in a more respectful and tactful way. When I asked him about the advantages of being indigenous over a *mestizo* sent to work in a place like Nariteri, he responded that he respects indigenous customs:

> *A mestizo health worker is not going to get used to be in a community that is far away. He might go back to his town after a week, crying. We have been born and brought up in a community, we get used [to be there] very fast. I have gotten used [to be here] very fast, I am here almost two years and I am not bored at all. Now, I say, they [Asháninkas] speak their own language and have their customs and I respect them, I do not tell them "you cannot do this." I only tell them that if they are going to prepare their masato, do it with some hygiene. I am not going to take their practices away from them, but they can be a little bit hygienic, wash their hands before serving the masato. That is what I tell them to avoid illnesses*[106].

[106] Porque un personal mestizo que se va a acostumbrar en una comunidad lejos, capaz de regresarse a la semana llorando. Nosotros hemos nacido y crecido en comunidad, al toque nos acostumbramos. y yo rápido me he acostumbrado y ya estoy casi como dos años y no me aburro para nada. Y ahora yo le digo ellos hablan su idioma y tienen sus costumbres y yo les respeto a ellos y no les digo que no pueden hacer así. Solamente les digo que si van a

Like Hugo, Javier, had developed a close relationship with people at Nariteri and did not hesitate to make suggestions to prevent illnesses, such as the one described above. Javier was also familiar with local traditions, local food and ways of life. This made people feel comfortable enough to share medical explanations grounded in indigenous understandings of disease with him, and even provide advice about food taboos (such as avoiding monkey meat while menstruating) so that Javier's wife could follow them.

However, Javier (and other INTs) sometimes found himself caught between two paradigms. Once, Nariteri's *Jefe* came to his house and asked him not to treat Doña Teresa's hemorrhage because she was believed to be a witch. Earlier that month a baby girl – Doña Teresa's granddaughter – had died of a strange illness that everybody said was caused by witchcraft (*daño*). Since that baby girl was Doña Teresa's third granddaughter to die in a similar manner, people in the community accused her of witchcraft. When Doña Elsa started bleeding due to a miscarriage, people asked the *Jefe* to tell Javier not to do anything to save her life and let her die. As much as Javier understood that it was possible that Doña Elsa was responsible for witchcraft that hurt her three granddaughters, he had to treat Doña Elsa. Javier went to Doña Elsa's house and stopped the hemorrhage after explaining to the *Jefe* that it was his responsibility as a health worker to prevent people from dying. Like other INTs, Javier had to learn how to handle the fine balance between respecting local customs and traditions and meeting expectations and protocols as state health workers.

There were other instances in which Javier demonstrated an intercultural health approach and adapted medical treatments to local practices. For example, once Javier and I went to visit a

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hacer su masato, que lo hagan con un poco de higiene. Yo no les voy a quitar sus costumbres de ellos, pero que tengan un poco de higiene, lavarse las manos cuando van a servir su masato. Eso es lo que se les dice para evitar un poco las enfermedades.

5-year-old girl who had been having diarrhea for a couple of days. He took Oral Rehydration Salts (ORS) and rather than just explaining to the girl's mother how to prepare them, he actually stayed there waiting for the water to boil, then helped the mother wash a jug (into which the ORS would be dissolved) and waited for the water to cool down. Afterwards he showed the mother how to prepare the ORS and made sure the little girl took at least one cup of ORS before he left the house. It was apparent to me how much he cared for people's health. He explained that at first he would just explain to mothers how to prepare the ORS and how often to administer them, but he soon realized mothers would often prepare the ORS in water that had not been boiled (*agua cruda*) or they would use mugs that were not clean, putting the child at risk.

Javier's work at Nariteri demonstrates several examples of intercultural health care and the situations that can arise during health care delivery in an indigenous community. Javier had a close relationship with the community, and tried to be respectful of their traditions. He also had a close working relationship with indigenous healers and the ability to combine both medical traditions when necessary. Furthermore, Javier tried to start a medicinal garden at Nariteri but had not yet had any success when I visited him.

4.1.3 SERVANDO AMONG THE SHIPIBO-CONIBO

Servando was a Shipibo working in a Shipibo-Conibo community close to his own community. Before being hired as a health worker in Shipaya, Servando was very active in his community and held several political positions among the Shipibo-Conibos of the area. He was the president of the local indigenous organization (ORDECONADIT - *Organización de Comunidades Nativas del Distrito de Tahuanía*) that represented around six Shipibo-Conibo

communities. In 2005, when he was selected to go to Atalaya to become an INT, he knew he wanted to return to his community to provide health services.

At first, it was not easy for Servando to get a job in or around his community because there was only one Health Post. A *mestizo* health worker had been working there for a long time. A year before I arrived, the health worker resigned and the indigenous organizations requested the health authority in Atalaya assign Servando as the health worker. Servando thus had the support of his fellow Shipib-Conibos and he considered his assignment at the health post a responsibility and a commitment to his own people. He even told me "the day that they do not want me to work here anymore, I will leave."[107] For Servando, being assigned as a health worker in Shipaya was similar to holding a political position in an indigenous organization in the sense that it is crucial to have people's support to hold such a position. In both cases, he considered that he had the responsibility of doing his job as well as he could; whether it was about delivering intercultural primary health care or promoting the development of the communities affiliated to his organization.

Like Hugo and Javier, Servando was the only health personnel assigned at the Health Post. He also suffered from lack of medications; however, unlike the case of Hugo and Javier, Servando's health post was responsible for providing care to five other indigenous communities and not only to the 30 families that lived in Shipaya. The five communities the Shipaya's Health Post served were Shipibo-Conibo, Ashaninka and one *mestizo* community[108].

In Shipaya I observed Servando working side by side Doña Roberta, an elderly woman who was known to be knowledgeable about medicinal plants. One day, a man in the community

[107] El día que ellos ya no quieran que yo trabaje aquí, yo me voy.
[108] Having several communities to serve meant on the one hand that Servando had to organize visits to the other communities to vaccinate children and remind people that they can come to the health post whenever they feel sick.

was having intense eye-aches because wood splinters entered his eyes when he cut some wood without wearing any eye protection. Don Artemio, the man's father came to the Health Post and asked Servando to apply some eye drops to his son who was –at the moment– being treated by Doña Roberta. She knew how to use a plant's latex to collect the splinters in his lachrymal after which Servando applied the medicated eye-drops. Later, Servando also prescribed him some Paracetamol for his headache.

There were other instances in which Servando –just like Javier– would refer a patient to an indigenous healer. Servando would also use medications and medicinal plants for stomachache in tandem. In the cases where neither of these approaches worked, Servando would call the *onaya* (shaman in the Shipibo language) for help. In other instances, he would suggest a patient go to a particular indigenous specialist, such as the time when a woman came to the Health Post for her prenatal care. During the visit, Servando measured the woman's belly and touched it to feel the baby's position. He noticed that the baby was in a bridged position and told the woman she should go to one of the community's midwives to receive massages that would "accommodate" the baby and put it in a head-down position.

The INT sometimes referred patients to indigenous specialists but also used or prescribed indigenous medicines and remedies themselves. There were cases where the INTs prescribed indigenous treatments to be prepared and administered at home. For example, a mother once visited Servando who told him her young son had hurt his leg in a fall from the *emponada*[109]. Servando explained in detail all the plants the mother needed to prepare the medicine and apply it to the child's leg. Despite having knowledge about the indigenous treatment, Servando told me he did not volunteer to prepare it and apply it because he did not have all the necessary

[109] Emponada is like a porch. Houses are usually not built at the ground level but held by poles in each corner.

instruments (plants and pots that have not been used to cook food). He also had not followed the required diet before cutting the medicinal plants[110]. He explained the plants needed grow very deep in the forest and have to be picked early in the morning. He had so much work at the health post that it was not possible to do it, but could explain to the mother what to do. His way of using indigenous medicine was to teach the patient (or patient's relatives) how to prepare a specific indigenous treatment.

People in Shipaya heavily relied on Western medicine. There were two stores (*bodegas*) where in addition to canned food, over-the-counter medications for fever or painkillers, as well as antibiotics were sold. Buying medications from the bodega was one of the strategies people used when there were no free medications at the Health Post. Once, a woman came with her baby to the Health Post and asked me for "Antalgina" (*Metamizole*). I told her the health worker was in Atalaya attending a training session and that she should find the health promoter, who would probably be able to help her since he had the keys to the pharmacy. I met her the following day and asked her if her daughter was doing better. She replied "yes," so I asked if she had found the *promotor* the day before. She explained: "No Ma'am, I went to the bodega and bought an Antalgina to reduce my daughter's fever. Now she is doing better." This kind of behavior was not uncommon since people were familiar with medications and was is prescribed to treat common ailments.

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[110] In Amazonian terminology, "diet" does not refer exclusively to avoiding certain foods or types of foods (for example: fish with teeth or seasoned food). Diet also refers to a time of isolation in the forest that all dieteros (the ones who diet) must pass to allow intuitive communication with the "master plant" they have ingested. Depending on the master plant, the dieting time can range from a few days to several months (Nixi-Pae 2012).
There are other behaviors that have to be followed when dealing with medicinal plants. People in various communities explained me how certain plants need to be cut at sunrise or sunset so that they will have the desired effect. Shamans for instance, need to diet and abstain from sexual intercourse before cutting certain sacred plants. Healers of different types often need to sing to plants as they prepare them or apply them so that plants will "pay attention and do what they were asked to do."

I realized during my conversations with community members from Shipaya, Shari and Nairteri that many considered the availability of Western medications as an example of good health services. However, medicines were not always available at the Health Post due to a shortage of several medications in Atalaya. It has also been explained that the medicines needed to come from the nearest town and was not a straightforward process. For example, once Servando travelled to Bolognesi to submit a report and collect medications only to find that the Bolognesi Health Center had run out of its allocation of medications and used what was allocated for Shipaya as well. Servando had to return empty-handed to the community and explain the situation.

Servando had a close relationship with community members from Shipaya. It helped that he was a Shipibo-Conibo from the area. Once he had to evacuate three pregnant women who were presenting some pregnancy-related complications to the Health Center in Bolognesi. One of them was around six months pregnant and had been experiencing an intense headache which could have been a sign of preeclampsia (high blood pressure) putting both the woman and her baby at risk. The other two women were complaining of intense vaginal discharge and thought they were pregnant but were not sure. Servando's canoe was small and could not carry the three women, so he had to borrow a bigger boat and gasoline from community members. As a respected member from the community, it was relatively easy for Servando to get the boat and gasoline. People trusted he would return the gasoline he had borrowed.

4.1.4 SUMMARY OF STRATEGIES

Hugo, Javier and Servando were all working in a governmental Health Post as the only health workers assigned to serve the population of one or more communities. Yet, the context in

which they worked was different: Hugo and Javier did not speak the local indigenous language and were working in isolated places. Servando on the other hand, was not only working among his own ethnic group but also in a community close to his own community. Despite these differences, the three INTs were able to develop similar strategies to combine Western and indigenous medicine, refer patients to indigenous healers, and they were accommodating to the members of the community; for example they provided health care in people's homes rather than exclusively at the Health Post.

Despite the particularities of each context, each INT developed different ways to provide health services that incorporated (with different intensity and frequency) three core elements for intercultural health: respectful collaboration between two medical systems, open horizontal dialogue with community members about health care provision, and adaptation to the context in which they worked.

As stated before, none of the INTs were given guidelines about what activities or strategies to use to transform "regular" biomedical health services into intercultural ones. They all –in a way– improvised the shape of intercultural health based on their training in both medical systems, their role as health workers, and their approach to health as an indigenous person. The following sections summarize the strategies they used.

4.1.4.1 RESPECTFUL COLLABORATION BETWEEN TWO MEDICAL SYSTEM

In the three field sites presented, I was able to observe INTs conducting their work in a collaborative way, and using both biomedical practices and the indigenous medical system in a respectful way. There were three different forms of collaboration: sometimes INTs enabled and/or allowed patients to use indigenous medicine within the health facility; INTs participated

in or allowed the combination of biomedical and indigenous treatments; or INTs referred patients across medical systems.

Hugo and Servando did not have any reservations about allowing people using indigenous treatments at government health facilities. In some cases, the treatments were prepared and applied by the patient's family, in other instances the patient's relatives brought (or called) an indigenous healer to the health facility, and there were cases in which the INT himself applied an indigenous treatment at the health facility. The reason I highlight that all these occurred within the health facility is that this is a key difference with what occurred – as we will see in the following section – among those INTs working in Health Centers with other health professionals.

There were different reasons why INTs decided to use indigenous medicine to heal a patient. Sometimes it was because upon evaluation of the ailment, the INT decided that it required an indigenous treatment. One example of such a case was when Doña Elsa was frightened by the "*tunche*" in Shari. Hugo realized she needed to be "blown" (*soplar*) with tobacco and so he did. Other times, the patient's relatives knew the INT was knowledgeable of indigenous treatments and would request him/her to use them. This happened especially when the ailment has been classified as something that was more suitable to be healed using indigenous medicine. In that case, it was essential that the community were aware the INT had intercultural education in health. Sometimes INTs decided to use a medicinal plant to solve a health problem that could also be healed with Western medications, such as a pill, either because the INT trusted the medicinal plant more than the medication or because there were no Western medications available. This was seen in the case of Javier who used medicinal plants to stop a hemorrhage given that there were no anti-hemorrhage medications in stock.

Besides the use of indigenous medicine at health facilities, indigenous medicine was also used to complement or in combination with Western medications and/or treatments. The combination of medical traditions is a practice often quoted in examples of intercultural health (Ibacache Burgos, Chureo et al. 2001; Alarcón, Vidal H et al. 2003; INS 2010). There are diverse ways this combination occurs and it is not limited to having a medical doctor giving a pill and an indigenous healer applying some medicinal plant for the ailment. Sometimes INTs themselves would apply both treatments or - as shown in the earlier examples - the INT would use an indigenous principle (such as singing to a cough syrup before administering it) requesting the medicine to act effectively on the patient.

There were cases where the INTs made referrals between medical systems. Most of the referral cases I registered follow the following pattern: the INT would evaluate the severity of the ailment and decide whether it was beyond his knowledge and skills, sometimes referring the patient to an indigenous healer. That was the case of Javier and Doña Berta for example. In other cases, INTs did not exactly refer the patients to an indigenous healer or suggest the families use and indigenous treatment (this was Servando's case). Rather, they worked side-by-side with an indigenous healer, such as when Javier and Doña Berta assisted each other during the birth of a child in Nariteri. Referrals from the indigenous to the biomedical system were sometimes made by patients themselves. There were cases when after realizing that the treatment provided by the indigenous healer did not work, patients would make the decision to visit the Health Post.

4.1.4.2 HORIZONTAL DIALOGUE WITH COMMUNITY MEMBERS

Hugo, Javier and Servando had all managed to establish horizontal, friendly relationships with community members. This enabled INTs to negotiate with community members in medical decisions. For example, Hugo had to request that expectant mothers in the community let him

know as soon as they started to feel the contractions. He explained he did not want to interfere or violate their privacy but he needed to be ready (and close to the house or field where the birth was going to happen) just in case there were complications. These requests went against some indigenous principles of privacy, but Hugo negotiated with the women and the community, and devised a workable compromise for an uneasy situation.

Javier on the other hand had to deny the request from the community's *Jefe* to let a woman – suspected of being a witch – bleed to death. Javier had to explain his responsibility as a health worker to save lives, the lives of anybody in the community. Servando was able to secure support from community members when he needed to evacuate three pregnant women from the community and when he needed someone to bring medications to Shipaya from Bolognesi. These networks and friendships were important for the INTs to do their work as best as they could.

4.1.4.3 ADAPTING TO THE COMMUNITIES THEY SERVE

The three INTs working at health posts had learned to adapt to the context in which they worked. Hugo for example worked with the Nahuas who believed that receiving saline administered intravenously was important to heal an intense stomach pain. As long as Hugo was not running out of saline, he would apply it in order to appease the patient. However, Nahuas also liked to use antibiotics on a regular basis, especially when their babies and toddlers were coughing constantly. They feared it could be pneumonia and would request Hugo administer an

antibiotic shot[111]. In such cases, Hugo had to be careful and explain the potential harmful side effects of applying too much antibiotics to children.

Javier, on the other hand, who was working in a community without a Health Post, walked around the community daily and visited people in their homes to find out who was sick or pregnant. During his stroll around the community, he would also get to know people better (and vice versa) and remind them he was available to help in any medical concern or emergency. Servando was in charge of five communities and would program visits to each community to vaccinate children (rather than asking them to come to the Health Post).

4.1.5 OPPORTUNITIES AND CHALLENGES

The INTs who work at Health Posts had various opportunities to use an intercultural approach but also experienced some challenges. One important characteristic is that the INTs at the Health Posts worked alone and this gave them the freedom to make decisions at their own discretion. The INT could decide whether or not to allow an indigenous healer to come to the Health Post or to use an indigenous treatment rather than a biomedical one (or in some sort of combination).

Another positive aspect of the INT experience is that the INTs had a great familiarity with Amazonian concepts of illness, and they were familiar with common treatments and conceptions of the body. The INTs could understand their patient's concerns about doing something that might go against their understanding of an illness (such as avoiding certain foods that were not considered appropriate to consume when suffering a certain ailment, like

[111] It is important to remember that in the 1980s the Nahua population suffered from an epidemic of respiratory illnesses that killed a large proportion of the population. Please see Chapter 1 for further explanations.

consuming game meat after one has been bitten by a snake). INTs understand patients might be wary of following a particular biomedical treatment that goes against Amazonian understandings of an ailment, such as drinking a cold beverage while having a problem that produces "heat" in one's stomach. Other studies have similar findings, where Western treatments are rejected by patients because the treatment conflicts with indigenous understandings of the ailment or the treatment.

Pollock (1988) found that the use of ointment such as mercurochrome and gentian violet among the Amazonian Kulina Indians were easily accepted given their understanding that illnesses manifest themselves through the skin (and thus can be cured by applying substances on it). He also observed how Kulina Indians classify illness into external and internal illnesses, and they had no trouble in accepting injections and even oral medications (although with some level of skepticism). They were able to make sense of the idea of introducing medications into their bodies to heal internal problems (Pollock 1988).

In terms of the challenges the INTs faced in trying to use an intercultural approach, one of the major barriers was the bureaucratic structure of the national health system. This bureaucratic structure made it hard to promote the acceptance of indigenous medicine in the MoH more widely. As I have explained earlier, the MoH focuses on health workers meeting targets. These mandate limits the time INTs can devote to preparing indigenous treatments or participate in healing rituals. On the other hand, there are several barriers to registering and reporting the use of indigenous medicine at the Health Posts because of the national insurance *Seguro Integral de Salud* (SIS - Comprehensive National Insurance program). The SIS forms did not allow for reporting the successful use of indigenous medicine at a Health Post. Such reports

could, in the future, support the need to recognize the validity of indigenous treatments and the respect of indigenous healers.

As mentioned in Chapter 1, indigenous people living in communities similar to my field sites are covered by the SIS. Under this health insurance, health workers are allowed to give free medications to patients depending on the ailment and the standard treatment for that ailment. For example, if a patient has a throat infection and the established treatment is three pills a day for seven days, then the health worker will give the patient twenty-one pills. Health workers must enter a code indicating the diagnosis and the treatment offered. After providing patients with the exact number of medications for each full treatment, health workers have to note it down and submit a monthly pharmacy report.

At the end of each month, health workers must present various reports. One of them was a consolidated report of patient's visits, including any diagnoses and treatment provided. If the INTs had –for example – prescribed forty doses of anti-parasitic medications, they would receive another forty at the end of the month. They might also request more but given the limited budget, health facilities I visited were constantly running out of medications and would have to give only half the required treatment, or ask patients to buy them at a bodega[112] in the community (if there was one).

One problem for INTs when applying intercultural approaches to health services is that in the SIS forms there is no space to really describe some illnesses that are recognized by the indigenous medical system but not by the biomedical system (and thus, no SIS code exists). Another problem arose when the Health Post had no medications to heal a "Western" ailment or

[112] It was interesting to see that health workers will sometimes "hide" the fact they had medications from those patients they knew could afford buying medications so that they have medications left for those poorer members of the community.

the necessary treatment required the use of medicinal plants. There were no codes –according to INTs– to report their use of medicinal plants and its effectiveness. This shows the little importance the MoH is placing on the possibility of using medicinal plants to treat common ailments. Due to these limitations there were no records of the various times INTs used indigenous medical treatments and healed the patient which, in some cases, saved the MoH money since they did not have to provide the health facility with the medications used.

The second limitation that the system posed to INTs and health workers interested in using an intercultural approach was that health workers were evaluated by their capacity to provide health coverage to a large number of people. Health facilities had various quantitative targets to meet (immunizations of children under three, tetanus immunization for all pregnant women, pre natal care for all pregnant women, etc.). Health workers had to fulfill these targets in order to receive more state support for medications, human resources and medical equipment. If, through their reports, they showed that the number of people served by the health post was higher than the number officially registered in the MoH's statistics, this meant they were doing a good job.

Some of the targets are very demanding. For example one target requires health workers to vaccinate all community members in the health worker's jurisdiction just two days after receiving the vaccines. This makes it hard for health workers (*mestizos* or INTs) to invest the necessary time to explain the procedure to the people they treat. Given that intercultural health is also about being able to adapt the services to the local reality and to the characteristics of everyday life, the pressure that the MoH puts in meeting targets in short periods of time undermines the possibility of designing culturally-appropriate ways of delivering certain services. Once, while in Shipaya, Servando received an order through the ham radio to use all his

Hepatitis B vaccines because they were about to expire. We had to travel to the five communities served by his Health Post searching for people to vaccinate (pregnant women and children were a priority).

Another challenge to using medical plants on a more regular basis was that preparing them is not a straightforward process. Servando explained to me that his workload did not allow him to invest time in preparing medicinal plants. Medicinal plants require special types of processing to be effective, and this can be a time-consuming endeavor. Each medicinal plant can be combined and prepared in different ways. Plants can be boiled, cooked, ground, macerated, squeezed to extract its properties, or used as a compress, an ointment, an enema or boiled to generate steam for a vapor treatment (Jiménez Suárez 2006). Medicinal plants can also be used to paint the body or consumed as syrup. In the Amazon, there are several rituals associated with collecting, preparing and/or applying the plants on a patient. Consuming or using a medicinal plant-based treatment is more labor intensive for the healer and is not the same as taking a pill.

Even harvesting the medicinal plant requires special care and rituals, as shown in the video filmed in 2012 by Todd Swanson (Director of the Amazon and Andes Field School in Ecuador,) where two Kichwa women are harvesting the bark of a medicinal tree (*amarun caspi*). In the video, the women explain the various steps involved in the process of harvesting such tree.

> "*My husband and my parents always say that when we go to the forest to harvest medicine bark, [upon] arriving at the base of the tree whether it is callispua casi or amarun caspi or a balsamo tree (…) we should stand and talk to him, speak (to him). On this morning, we have come to this forest to take its bark. We who are called humans get sick, and we have a lot of pain in our stomachs and we have pain in our bones. It is for that reason that we come to take his bark this morning, and so this morning I have been speaking to this amarun caspi tree, I have been asking his permission…*" [113]

[113] Amazonian Kichwa Women Harvest Medicinal Bark - https://www.youtube.com/watch?v=tCQ9MpK9ntw

Afterwards, the harvesters perform a simple, small ceremony where they praise the qualities of the tree: strong, red, old, and ask him to give them the same qualities when they drink it. This video shows that harvesting a plant to cure an ailment requires a ritual that cannot be overlooked. The Kichwa women explain, for instance, that depending on the patient's gender, one should choose between a male and a female tree. If one is going to prepare medicine for a girl, one has to cut the bark of a male tree and vice versa, while singing to the harvested tree.

Unlike what some people might think, Swanson says that indigenous forms of medicine take a great deal of time to procure and prepare:

> "*most plant medicines are considerably more expensive in terms of time than are medicines from pharmacies. This is increasingly true as virgin forest gets depleted. You have to walk farther and farther away; sometimes a couple of hours. Then you have strip the bark from a tree and boil it. Often times the forest close by is owned by other people who may not want you to damage trees there*." (personal communication, 2013)

Thus, when INTs argue that preparing an indigenous medicine requires time and preparation (usually following diet restrictions), they are referring to the complexity of the process involved in preparing indigenous medical treatments.

Harvesting a medicinal plant even before preparing it to be consumed (through boiling, grinding, etc.) is, thus, a complex ordeal that "conflicts" with the time demands of a health worker responsible of filling mandatory monthly reports on several illness that are under epidemiological surveillance in the country, such as maternal mortality, tuberculosis, malaria and HIV/AIDS. Furthermore, Servando explained that you cannot use the pots or pans you use to prepare your everyday food to cook a medicinal plant. He said you have to have a separate set of pots, pans, and spoons because otherwise the medicinal plants will not "work". New pots and pans are expensive utensils for a health worker, and –he said– if the MoH supported the use of indigenous medicine, "*they would be providing us with all those implements we need*".

For Hugo, supporting indigenous medicine was not just about providing the right equipment to prepare the treatments, but also about the ability to train in indigenous medicine. Hugo told me that local health authorities would sometimes call on health workers to participate in training sessions on biomedical issues, covering all their travel expenses. Hugo pointed out that if health authorities really wanted to encourage the use of indigenous medicine they could also do the same to support trainings about medicinal plants and not only about biomedical protocols. Hugo told me he would like to travel to Atalaya and participate in more ayahuasca rituals with a Maestro Ayahuasquero. In such way he would learn more about the healing properties of medicinal plants. As I have stated earlier, medicinal plants, such as ayahuasca, do not only have a therapeutic function. Some medicinal plants, known as master plants, are also a source of knowledge and of powers that enable certain people to heal others (Reategui Silva 2008).

> The master plants are those that provide lessons about its medicinal properties when ingested. They also teach lessons on the art of living in harmony with the environment. Healers say that each plant has its genius, the "mother plant", which must be respected. Some “master plants” (*plantas maestras*) have psychotropic properties and some not. Communication with the plant occurs in several ways: in dreams, using intuition or with visions (Nixi-Pae 2012, personal translation).

The spirit of medicinal plants can teach one how to use them, and their spirit (also known as the mother of the plant), has its own will to do things (Reategui Silva 2008). Preparing medicinal plants or consuming master plants to increase one’s medicinal knowledge was not easy given the workload of INTs. Furthermore it was not part of the training sessions offered for health workers.

4.2 INTERCULTURAL HEALTH EFFORTS AT A HEALTH CENTER

Imelda, Norberto and Mario are the three INTs I visited who were working at a Health Center. Imelda and Mario were working at the same Health Center. However, upon a revision of my field notes I realized I did not record any concrete example of Mario using an intercultural approach. One of the reasons for this is that the Health Center at which he worked was not one unified building but rather three separate spaces. Mario was assigned to the triage section where his role was to screen patients and tell them whether they had to go to see the doctor, midwife or nurses that provided vaccination and childcare. His job was also bureaucratic. He was in charge of finding the patients' personal records, verifying that they had their SIS and taking them to the room they were supposed to go. Furthermore, Mario was working among the Ashéninkas although he was Yine, and he did not speak the language although he was very friendly with all patients. Mario himself told me he did not have many opportunities to apply indigenous medicine. At the most he would discuss (with those who spoke Spanish), the dreams the patients might have had that could provide information about the source of the illness, or who had sent them the misfortune[114]. Mario explained he did not share this information (the dreams) with the *mestizo* health workers because he assumed it would not be taken it seriously.

In the following sections, I will describe the experiences of Norberto and Imelda working at Health Centers. Norberto worked at the Bolognesi Health Center and Imelda worked at the Oventeni Health Center. I will complement what I was able to observe firsthand with experiences related to me through interviews. I interviewed two INTs who had previously worked at the Bolognesi and Atalaya Health Centers. Ernesto had worked at the Bolognesi

[114] The importance of dreams as sources of knowledge and channels to cross realities according to Amazonian worldviews have been studied by several authors (Conklin 2002; Shepard Jr 2002; Peluso 2004).

Health Center and Oscar had worked at the Atalaya Health Center. I was able to interview the INTs in Atalaya and collect examples of their efforts at using an intercultural approach in the Health Centers where they had formerly worked.

4.2.1 NORBERTO IN THE BOLOGNESI HEALTH CENTER

The Health Center in the town of Bolognesi served a population of more than 5000 people, most of them from Shipib-Conibo and Asháninka communities along the Ucayali river. Norberto was one of the six nurse technicians staffed at the health center together with four other health professionals. His salary was not paid by the MoH but rather by the Municipality after the health center requested the mayor hire two translators, one that spoke Spanish and Asháninka and another that spoke Spanish and Shipibo. The request to hire translators came after group of health workers were held hostage in a Shipibo-Conibo community after a child died there after being vaccinated.

I was told that two years earlier, in 2009, a group of health workers traveled to a Shipibo-Conibo community called Puerto San Juan[115] to administer the second dosage of the MMR vaccine against mumps, measles and rubella. As soon as they got off the canoe, the community held the health workers captive and accused them of plotting to kill the communities' children. The misunderstanding was solved after the health workers were able to explain that the child's mother neglected to tell them her child was sick with a fever when they vaccinated him the first time[116]. As a result of this situation the mayor decided to hire two bilingual health workers and

[115] Name changed.
[116] This story was told to me again in a Shipibo-Conibo community but in that case, it had been the indigenous organization the one who had requested the mayor to hire the bilingual health workers

pay their salaries from municipal funds. These bilingual health workers were called "*los interculturales*" by the rest of the staff and they would occasionally be called to translate for the doctors and nurses.

Unlike INTs working at Health Posts, Norberto's coworkers did not know he held a degree as an intercultural nurse technician. They knew he was Asháninka and that he spoke that indigenous language, but they did not know about his training as an INT. When I asked Norberto why he had not told his co-workers he had been trained in both medical traditions, he told me that he never got a chance to inform them. Those coworkers who were closer to Norberto knew about his training but they did not seem to give much importance to such training. Norberto's coworkers were a doctor, a nurse, a midwife, a dentist and five other nurse technicians. By the time I visited Norberto I had already completed my field research with Hugo and Javier at the Health Posts, so it was easier to gear the conversations towards examples of intercultural efforts. We were discussing the possibilities of using (or allowing the use of) indigenous medicine at the Health Center. Norberto explained that it was complicated, especially since it was not up to him to make those decisions. As a nurse technician hired by the Municipality, he was low in the pecking order of authority at the Health Center. However, he managed to find ways around this hierarchical structure and facilitate the use of medicinal plants for indigenous people who came to the Health Center from their communities.

Norberto told me that some months before a woman came to the facility to give birth. While the health personnel waited for her to be fully dilated, her mother brought a decoction of Pacunga (*Bidens pilosa*), an Amazonian medicinal plant used to accelerate the birthing process. Norberto was careful that the other health workers did not see her administering the Pacunga, since he was aware his colleagues were not very tolerant towards the use of indigenous medicine.

There was even one male midwife who opposed women taking any form of medicinal plants before or during labor. He forbade them from bringing medicinal plants (he just used the term "*plantas*") since he was convinced either they had no effect or caused "fetal suffering"[117]. Hiding the use of medicinal plants from their coworkers was one of the strategies that Norberto (and the other INTs working at Health Centers) developed.

Like Norberto, Ernesto also found ways to help indigenous people bring medicinal plants into the Bolognesi Health Center. He told me about a case in which an Asháninka family brought their medicinal plants into the health facility because the child had *mal aire* and not whooping cough as he was initially diagnosed with. Ernesto narrated the following episode:

> One day there was a patient who brought his *piri piri*. He had brought his things [medicinal plants] and his child was on a stretcher. The doctor sees the child and diagnoses him with whooping cough, but in the end, it was "*mal aire*". It was not whooping cough because when you have whooping cough, the cough is dry and this cough was increasing. So, they [the patient's family] brought their *piri piri*, their *sharamate*, the *tunche* flower. I told them "smash them and then bathe him." They lit their fire there and two days later, the kid was healthy.[118]

In this case, Ernesto even helped with the instructions to prepare the treatment because – as he explained later– he had learned about a similar treatment while studying in Atalaya. Ernesto did not say whether the other health workers in the Health Center were aware that patients' relatives were administering an indigenous treatment at the health facility. Based on other comments he shared with me during our conversation, it seemed that he tried to hide this

[117] When I asked how he knew there was fetal suffering he explained that when women take *piri piri* the amniotic fluid was green and opaque instead of transparent. From his perspective, it was not possible that a green amniotic fluid did not affect the baby. However, upon conversations with obstetricians in Lima, I was told that when babies defecate just before birth, the amniotic fluid turns dark.

[118] Un día una paciente había traído su piri piri. Había traído sus cosas y estaba su chiquito en una camilla. La doctora lo ve y dice que tenía tos ferina. Total, era mal aire. No era tos ferina porque cuando tienes tos ferian [la tos] es más seca y se aumentaba la tos. Entonces han traído su piri piri, su sharamate, su flor de tunche. "Chapéale" le digo "báñale." Allí han hecho su candela. Total a los dos días el niñito ya estaba sano, lo bañamos…"

event from the rest of the staff, especially since the treatment challenged the diagnosis given by the doctor.

One main obstacle for the use of an intercultural approach at a Health Center was the attitude of other workers towards indigenous medicine. For instance, Verónica, the doctor at Bolognesi did not trust indigenous medicine's efficacy and once told Norberto that indigenous treatments were "garbage" (*basura*). When I interviewed Dr. Véronica, she told me she "tolerated" indigenous beliefs that she considered innocuous for people's health condition. But Dr. Verónica's negative or 'tolerant' perception of indigenous medicine and Norberto's respect towards indigenous medical practices once led to an impasse between them. Norberto explained that his wife was pregnant, and four months ago a patient who had been bitten by a snake came into the health center. Dr. Verónica sent Norberto to see him. Norberto refused because his wife was pregnant and Norberto feared his presence could kill the snakebitten patient.

> "*For example, once there was a patient with ophidism [bitten by a snake], I am not going to see that patient. I was on call that day.* ***"Why weren't you going to see him?"*** *[I asked] "Because Carola [his wife] was expecting and if I go and see him it is going to be worse [for the patient]". So, I went and told Facundo [another INT] "You go and see the patient." And so it happened. The doctor came afterwards and scolded me "why don't you see the patient? You have to see him!" My beliefs are aside. We have a patient with that [ophidism] and that [seeing him when my wife is pregnant] is going to hurt him, my wife can kill him. But afterwards the doctor tells me "if you believe in your beliefs, believe then", I let her scold me*" [119]

Among indigenous people (as we saw in Javier's story in Nariteri) it is believed that it is harmful for a pregnant woman, or somebody who has had sexual intercourse the night before

[119] "Por ejemplo había una vez un paciente con ofidismo [mordido por una serpiente]; yo ese paciente no lo voy a ver. Es día estaba de turno. "¿Por qué no lo vas a ver?" "Porque la Carola [su esposa] estaba gestando y si yo voy a verle le va a chocar más". Y yo le digo a Facundo [otro técnico intercultural], "tú ve al paciente". Y así pues. La Doctora después me ha reñido "¿porque no ves al paciente? ¡Tienes que verlo!" Mis creencias son aparte. Tenemos un paciente con eso y le choca, le puede matar mi esposa en un instante. Pero después, la Doctora me dice "si tu crees en tus creencias, cree pues," me he dejado reñir."

(*mal dormido*), and/or for someone whose wife is pregnant to visit a person who has been bitten by a snake. Indigenous people from the field sites I visited explained that the presence of a pregnant woman or the husband of a pregnant woman can intensify the effect of the venom.

In this particular case, Dr. Veronica's disbelief in indigenous conceptions about snakebites led to her getting upset at Norberto. She scolded Norberto for not following her orders, although eventually she accepted that Norberto had "his beliefs" ("*sus creencias*"). This – Norberto told me – did not mean she changed her mind about indigenous medicine. Norberto was aware that he had to be careful about suggesting patients use indigenous treatments when Dr. Verónica was around, since he wanted to avoid being scolded again.

On another occasion, the Health Center was short on several basic medications and a child was admitted with acute diarrhea. Health professionals did not know what to do. The standard treatment was to rehydrate the patient using saline, but they had run out of saline and they also wanted to stop the diarrhea. Norberto suggested that he could use boiled *guayaba (Psidium spp)* leaves to stop the diarrhea and rehydrate the patient. The doctor was not present at the Health Center and given the urgency of the case, the other health workers told him to try to use *guayaba* leaves. Norberto prepared an infusion out of *guayaba* leaves and managed to improve the patient's condition. His co-workers were relieved. This shows that under certain circumstances, *mestizo* health workers will not oppose INTs' use of indigenous medicine, but from my conversations with *mestizo* health workers, it became apparent this was hardly the norm. I was not able to find one *mestizo* health worker (among the ten I interviewed) who used medicinal plants. As Wayland (2003) states, despite the fact that numerous studies report physicians are increasingly accepting complementary and alternative medicine, these studies find that doctors' endorsement and use of medicinal plants for treatment is very low. They also rarely

refer patients to indigenous healers and have little confidence in medicinal plants.

4.2.2 IMELDA IN THE OVENTENI HEALTH CENTER

Like Bolognesi, Oventeni was a town inhabited by *mestizos* but surrounded by indigenous Ashéninka communities served by the Health Center. Imelda, one of the INTs who worked at the center was an Ashéninka herself and lived in the neighboring community, twenty minutes walking-distance. Mario, her boyfriend, was also an INT; however, as I explained in the introduction to this section, he did not use an intercultural approach, mostly because he was assigned in the triage section of health services. Imelda however helped in immunizing children.

Oventeni's Health Center also had a full medical team comprised of a doctor, a nurse, an obstetrician and three other nurse technicians. Imelda had been working there for a year and other health workers relied on her for translation since she was Ashéninka. Imelda, like Norberto in Bolognesi, did not feel comfortable openly using indigenous medicine at the Health Center. She had trepidation about how her co-workers might react. However, Imelda used her ability to speak Ashéninka to hide her recommendations from her coworkers. When she realized that a patient's ailment could be healed with an indigenous treatment she would tell the patient (in Ashéninka) to come after working hours to her house, where she could administer the treatment. Ernesto – from Bolognesi – also provided an example of a similar situation in which he told a patient to come to his room after the Health Center closed so that he could use an indigenous treatment for the patient's ailment.

Imelda was one of the few INTs that spoke to me openly about the need to promote indigenous medicine and recover any lost or diminished knowledge. She was concerned about indigenous people's increasing reliance on Western medicine, especially since – as I have

explained earlier – oftentimes there are not enough medications at the health facility and the ones sold in *bodegas* are not always kept in the required sanitary and temperature conditions.

Imelda promoted the use of medicinal plants among people from the communities. She would tell them they could use this or that plant instead of the pill prescribed by the physician (for a fever, for example). She told me that when at the Health Center Imelda suggests people should use medicinal plants over Western medications. She would ask: "Don't you know that this medicinal plant can also be used for that ailment?" and people would tell her "That's right, how come I forgot!" Imelda considered it part of her responsibility as an INT to advocate for the effectiveness of indigenous medicine, not only among her colleagues but also among people in the community.

For certain ailments such as snakebite, indigenous people from Oventeni were savvy. Just a week before I arrived a man was bitten by a snake on his right hand as he was picking coffee. His wife applied a *piri piri* for snakebite and then went to the Health Center where the doctor prescribed a painkiller and an anti-inflammatory cream. Imelda knew of other medicinal plants for snakebite, and so she told the man to come to her house at night, where Imelda treated him for several days. Imelda however did no share what she did with her coworkers who were impressed by the progress made by the man. Imelda choose to be secretive about her knowledge of indigenous medicine since she believed it would not be appreciated at the Health Center.

4.2.3 OSCAR AT THE ATALAYA HEALTH CENTER

Oscar was an INT who worked for some time at the Health Center in Atalaya. Just like Norberto, Ernesto and Imelda, Oscar worked as part of a medical team where indigenous medicine was not perceived as a valid part of a patient's treatment. Oscar was more outspoken

than the other INTs I met, and he made efforts to demonstrate that indigenous medicine was effective. This implied that there were times where he had to confront his colleagues. For Oscar, one common problem is that mestizo doctors always interpret ailments using the biomedical model and do not allow for the possibility that an ailment might be caused by something they do not know or understand. This happened while he worked at Atalaya's Health Center:

> "For example when somebody has "*mal de gentes*" [it has to be cured with indigenous medicine]. In this world, there are envious people who tell you "Why are you like that?" (...) And they live their lives *"salados"*, with bad luck, you're unhappy with your life, you live worried. There are herbs that can make a person feel happy or to stop worrying. So, when you put an injection to such persons, it will not cure him/her, on the contrary, you are going to [make him/her] get worse.
>
> For example (...) when I was in the Health Center [in Atalaya] (...) there are doctors who do not believe in indigenous beliefs, they do not believe in other people's beliefs. (…) [They say] "No, that does not exist." Then, when I was there [working at the Health Center], I argued with the doctor. One time they brought a child [with diarrhea, and] the first thing [the doctor] does, is put an intravenous device, [and] he dies [due to] liquid overload. Then (...) analyzing, [since] I have studied as intercultural [nurse technician], [I know that] this is not treated like that. First, you have to evaluate. (...) For a simple minor diarrhea, we cannot put serum intravenously. **Why?** Because the child is not dehydrated. If the child is dehydrated, then we can put saline through an intravenous device [but if not] it is not appropriate. [What we should do is ask] "Are there medicinal plants available?" "This is *mal aire*". [Mal aire] can be diagnosed through the [patient's] feces, we call that *mal aire*. So in order to heal someone with *mal aire* we will prepare the medicinal plants - if we had them there-, and we will apply them three times. The doctor told me, "You think you're doing good things only because you think you're doing [well]? You are using the devil." I said: "First, the reason why children die is because they get a [saline] overdose. When you introduce lots of fluids to the body, then the fluid goes to the lungs and then it kills him." So to avoid this, first you have to observe, sort [the type of illness]. If a child is dehydrated, then it is obvious we need to put the intravenous device (…) but not when the child is chubby, not when he has a simple minor diarrhea. **Why?** Because the doctor already knows: you get diarrhea not because there is something wrong but because you are cleaning your body. Our body is getting rid of all microbes that are bad, the child is getting rid of them. If I put saline intravenously, I interfere [with the cleansing process]. [120]

[120] Por ejemplo cuando hay mal de gentes [se debe de curar con medicina indígena]. En este mundo hay gente envidiosa, que te dice "¿por qué eres así?" (…) y vives, salado, con mala suerte, estás con la vida desgraciada, vives preocupado. Hay plantas medicinales que pueden hacer a la persona sentirse feliz o no preocuparse. Entonces cuando tú pones una ampolla a ese tipo de personas, no va a curarlo, al contrario lo vas a empeorar. Por ejemplo (…) cuando yo estaba en el centro de salud (…) hay doctores que no creen las creencias de los indígenas, no creen lo que es otra creencia, ellos no creen "No, que no existe." Entonces yo cuando estaba allí, yo discutía con el doctor. Venía

Oscar's story shows two important aspects concerning the relevance of working among colleagues who support the use of indigenous medicine. Like the other INTs, Oscar made distinctions between illnesses that are appropriate or respond well to indigenous plants (such as envy and *mal aire*) and those in which Western medications will actually have no effect or even a negative effect to the point they may actually endanger the patient. In the case of the child with *mal aire*, Oscar explained that injecting more liquids into the child's body caused the child's death because the body was trying to get rid of the illnesses through the diarrhea. Western doctors' limited understanding of indigenous illness-causation models can lead them to make treatment mistakes with terrible outcomes (according to the INTs).

Another important dimension of this example is the physician's reaction to Oscar's suggestions to use an indigenous treatment for the *mal aire*. The physician's remarks were sarcastic ("*Do you think you are doing any good with that treatment?*"). The physician also accused Oscar of using "*cosas del demonio*" (devil's doing). Despite Oscar's efforts to explain why he was using an indigenous treatment, the doctor did not understand.

There were other instances where co-workers were actually more open to Oscar's explanations and suggestions regarding ailments. On one occasion, Oscar was allowed to use an

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un niño [con diarrea] y primeramente qué hace, le pone una vía, le carga sobre líquido y fallece. Entonces (…) analizando, yo que he estudiado como intercultural, [pensé] esto no se trata así. Primeramente, tienes que evaluar. (…) Por una simple diarreita nosotros no podemos poner una vía, ¿por qué? porque no está deshidratado. Si el niño se ve que esta deshidratado, entonces allí sí podemos poner una vía. Esto no es apropiado... entonces vamos a hacer esto... ¿hay plantas medicinales? "Esto es mal aire" eso se puede diagnosticar de sus heces, le llamamos mal aire. Entonces ¿cómo crees que se va a curar? así si nosotros teníamos allí preparado, y tres veces le ponemos. El doctor me dice "¿tú crees que estás haciendo cosas buenas? solamente porque piensas que estás haciendo [bien pero] tú estás utilizando al diablo." Yo dije, "en primer lugar por eso se mueren los niños: le cargan sobredosis [de suero], y cuando le ha entrado mucho líquido al organismo, entonces esto va al pulmón y entonces esto lo mata". Entonces para evitar esto, primeramente tienes que ver, clasificar. Si un niño está deshidratado claro que se necesita ponerle la vía. ¿No se puede poner una vía? Sí se puede, pero en su momento, pero no cuando esta gordito, por una simple diarreita ¿por qué?, Porque el doctor ya sabe: la diarrea que te da no es porque sea malo sino es porque te está limpiando. Nuestro organismo de nuestro cuerpo trata de botar todos los microbios que son malos, el niño va botando. Si yo le pongo una vía… interfiere [con ese proceso de limpieza].

indigenous treatment after the Western treatment did not work. There was a teenager who appeared at the Health Center with pain in his leg. Upon screening him, a *mestizo* health worker diagnosed him with "cellulitis"[121] and told Oscar to administer a penicillin shot. The penicillin, however, "would not listen" (*no hacía caso*)[122] as Oscar explained and the patient's condition did not improve. The shot only seemed to alleviate the pain for two or three hours. The patient would return to the Health Center complaining the medication was not working.

Oscar finally worked up the courage and told his colleague "*we should not be administering penicillin because what this child has is* "*mal de arcoiris*" (rainbow disease)[123], *and in order to heal it you need to use medicinal plants*." Despite the health worker's lack of faith in Oscar's diagnosis, his coworker did not object to Oscar going to the patient's house to use medicinal plants. Oscar picked a *piri piri*, mashed it, mixed it with alcohol and applied it in the patient's leg for three days until the inflammation was gone. The patient's mother was satisfied with the result.

Examples like the one just narrated and the example where Norberto treated a child's diarrhea using *guayaba* leaves show that under certain circumstances, INTs manage to use

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[121] Cellulitis according to biomedicine is a bacterial infection of the skin and tissues beneath the skin. Unlike impetigo, which is a very superficial skin infection, cellulitis is an infection that also involves the skin's deeper layers: the dermis and subcutaneous tissue. The main bacteria responsible for cellulitis are Streptococcus and Staphylococcus ("staph"), the same bacteria that can cause impetigo (source: Medicinenet.com accessed August 29th, 2012)

[122] Both INTs and indigenous people would talk about plants and Western medications as entities with willpower.

[123] Valadeau et al (2010) recorded the rainbow disease among the Yanehsas. The description they give fits with the ones I also heard in Atalaya: "people pay special attention to the apparition of infected red pimples, or itchy vesicles on the skin. These diseases,named Ayona'achartan "the rainbow hurt my skin" are said to be caused by the spirits of the rainbow, and this dermatological problem would be the result of a chock with one of them. Male or female, these spirits dwell in places where there is water (a lake, or stagnant water, or a humid place), or live in trees or in special stones. They make people sick because they want to live with him/her, after his death. They generally attack most vulnerable people, like children or pregnant women in great danger to suffer from premature birth, or miscarriage. People get sick when they walk through places of residency of these spirits, i.e. when they bath in the river, or walk when the sun is shining under the rain. Valadeau, C., J. Alban Castillo, et al. (2010). "The rainbow hurts my skin: Medicinal concepts and plants uses among the Yanesha (Amuesha), an Amazonian Peruvian ethnic group." Journal of Ethnopharmacology **127**(10): 175-192.

indigenous medicine openly and demonstrate its effectiveness. However, according to INTs like Oscar these isolated success stories did not lead to an increased acceptance of the use of indigenous medicine at the health center. According to Wayland (2003), the resistance to better acceptance of indigenous medicine by health professionals is based in part on the perception that the curing potential of medicinal plants poses a challenge to the authority of biomedicine. This is where the professional authority of the health workers comes from.

As explained earlier, one core component of intercultural health efforts is accepting the possibility of combining indigenous and Western medicine as two equally valid knowledge systems. This appears to be a difficult step for to take for health workers who are trained exclusively in biomedicine. However, indigenous people in the Amazon have learned to combine both sets of medical principles to address their health problems. The use of multiple medical systems presents an ongoing challenge for health workers not trained in healthcare delivery in a medically-plural setting. State health workers continue to see indigenous medicine as a competing and inadequate system of care, rather than as potential partner in to addressing health needs. This undermines the potential for the INTs to transform the way PHC is delivered in indigenous communities.

4.2.4 SUMMARY OF STRATEGIES AND CHALLENGES

There were very few opportunities for INTs to use indigenous medicine at Health Centers. There were also few opportunities to suggest such alternatives to patients. Indigenous medicine was only used openly when there were no medications at the Health Center and the INT suggested an alternative indigenous treatment, when a biomedical treatment was not being effective, or when an indigenous ailment had been misdiagnosed as a biomedical one. For the

most part INTs only administered indigenous medicine when they were sure none of his *mestizo* colleagues were looking. Ernesto and Norberto would ask indigenous patients to come to their home at night so that they could give them an indigenous treatment on the sly. Imelda told me she did the same, but she would use to her advantage that none of her coworkers spoke Asháninka. She would tell the patients in Asháninka to come to her place later in the day.

Some INTs looked for opportunities to explain the effectiveness of indigenous medicine to their *mestizo* colleagues. They were not always successful unless an opportunity arose for them to use indigenous medicine to heal a patient in front of their colleagues, and the treatment was successful. However, the opportunity to use indigenous medicine seemed few and far between. The use of indigenous medicine at the Health Centers where INTs worked was an exception rather than a rule.

One of the main challenges for INTs working at Health Centers is that they are nurse technicians and not college-level health professionals. Their opinions were not always solicited and they occupied a lower status within the Health Center's organization. As nurse technicians with a technical degree, they were given the simplest tasks such as triage, organizing supplies or preparing dressings like cotton balls, or even running errands. As an indicator of the hierarchical relationship between Dr. Verónica and the INT, she stated she was very fond of Norberto because he was "obedient." Even Norberto himself said that they appreciated him because he was obedient.

The hierarchical relationship between *mestizo* health workers and INTs was also influenced by the ethnicity of the INTs (e.g., indigenous people) and the *mestizo* co- wokers' lack understanding of indigenous medicine and indigenous culture. If this scenario is used to understand some of the necessary conditions to successfully implement an intercultural approach

to health care, it is clear that the majority of health workers need to have an awareness of indigenous medicine, be supportive of the idea of combining medical systems, and use more than one framework of knowledge. As shown in this section, just one health worker amidst others who do not know about indigenous medicine and do not understand it will jeopardize the potential of an intercultural approach. This idea even appears in the MoH's Norm (analyzed in Chapter 3), stating that the MoH should promote diversity in medical understanding:

> "Promote among the agents of the Western health system, attitudes of respect to difference and diversity, as well as attitudes of recognition and appreciation of the contribution of traditional medicines." (MINSA 2006) [124]

Yet these instructions are not followed in any of the health facilities I visited and they are not part of everyday medical practice. Only the INTs themselves promoted this kind of approach at Health Posts and Health Centers.

4.3 CONTEXTUAL CHALLENGES FOR INTS

In the previous sections I presented examples of how the INTs find ways of using an intercultural approach in the health services they provide. There are a number of challenges to effectively using intercultural medical practices which include but are not limited to the attitudes of *mestizo* colleagues towards indigenous medicine. There are also workplace constraints that are caused by insurance procedures and epidemiological protocols prioritizing certain health conditions and problems over others. There are also two other challenges at effectively using an

[124] Promover en los agentes del sistema de salud occidental actitudes de respeto a la diferencia y la diversidad así como de reconocimiento y valoración de la contribución de las medicinas tradicionales.

intercultural approach to health care: the increasing reliance on western medicine by indigenous people and the limited use of indigenous medicine.

As explained in Chapter 2, since the beginning of AIDESEP's PSI, there was a need to "convince" people in indigenous communities that it was worth promoting and continuing to use indigenous medicine. For AIDESEP it is crucial that INTs have the support of the indigenous communities they work in. To begin with, it is only with such support that INTs will be hired, as occurred in Servando's case. In all the field sites, the communities were happy with the work provided by INTs. However, the ability of the INTs to use both medical systems did not appear to be the most important quality people mentioned when I asked them about what they liked the most. Rather, having a health care professional who could provide Western medical treatments living in their communities was what people said they appreciated the most. Through their work, INTs had to slowly make people in the communities realize the importance of having somebody who also understood and practiced indigenous medicine.

During my research, it became evident that indigenous people demonstrate a growing reliance on Western medication. This is something that Juan Reátegui from the PSI told me about during an interview in 2008:

> "[t]here is already a sector of the [indigenous] population who rants about their own medicine, [who] does not believe in it. This attitude [towards indigenous medicine] is not just because it has changed, education itself is shifting, because [education] has demonized indigenous science, indigenous medicine, ancient wisdom; the Catholic Church, the evangelical churches, well... they have demonized [indigenous medicine] also. And even the traveling salespersons who sell expired medicines [in indigenous communities] tell people "these things [indigenous medical practices] are not useful." Because they want to sell their products. So all these factors have influenced [current indigenous perceptions of their own medicine]... plus, things change. The young people can no longer diet, they do not want to diet in order to learn the ancient wisdom through drinking ayahuasca, toé or tobacco, or strong medicinal plants. [To use these plants] for example, it is necessary to diet, you have to have discipline. Young people are not prepared for that since the education [received in schools] gives them another concept of life, another way of looking at life (…) And I see that it is not right for indigenous

cultures (…) So this is helping people to gradually lose their culture, their identity…" [125] (Reategui 2008, interview)

Reátegui was not the only one to think this way. Dilberto, a former leader of the ORAU (*Organización Regional Aidesep Ucayali*) expressed similar views during an interview. When I asked Dilberto for his opinion on CENSI's method of consulting with community members about the types of services they would like to receive at the local health facility, Dilberto told me he was not sure the way to improve health services was to ask indigenous people about their needs and wants. He was concerned his people (*Shipibo-Conibos*) will ask for "more pills, more doctors and bigger facilities" rather than requesting governmental support to help revive indigenous medical traditions and continuing the use of medicinal plants.

Dilberto's concerns echoed my conversations with people in Shari, Nariteri and Shipaya regarding the importance of having an INT (rather than a *mestizo* health worker) assigned at the health facility.

On the other hand, in my conversations with women in the communities I visited, their complains about health services revolved on medications and health personnel rather than on cultural competence. Whenever I asked people from these three communities about what they would like to improve in the Health Post, the two most common answers were "*more medications*" and "*another health worker so when this one has to leave for a training or to*

[125] Hay ya un sector de población que despotrica su propia medicina, no cree. En primer lugar no es sólo porque ella solo ha cambiado porque la educación misma está reorientando así porque han satanizado tanto a la ciencia indígena, medicina indígena, a la sabiduría ancestral, la iglesia católica, las iglesias evangélicas, en fin… ellas han satanizado tanto . Y hasta los propios comerciantes que llevaban a vender sus medicinas pasadas por allí de paso "que no sirve lo de acá" porque querían vender sus productos. Entonces todos esos factores han influido… y además las cosas cambian. Los chicos ahora no pueden dietar, no quieren dietar para prender la sabiduría ancestral deben tomar la ayahuasca, el toé el tabaco, o las plantas medicinales fuertes, por ejemplo requieren hacer dietas, muchas disciplinas que cumplir, entonces los jóvenes no están preparados porque la educación les da otro concepto de vida, un modelo de vida, no? Y que veo que no es lo más adecuado para las culturas indígenas, no? Entonces esto está ayudando a que vayan perdiendo progresivamente su cultura, su identidad, no?

submit his reports, somebody will stay at the Health Post." Furthermore, some people from Shari, Nariteri and Shipaya associated "community improvement" with the availability of Western medications. The ex-*Jefe* of Nariteri was one of them, stating that:

> "Yes, we have people in the community who know how to use medicinal plants for snakebite or diarrhea but now **we are moving forward and now we want medicine**… it is about time. Before, we did not use to know anything, there were no medications. But now we have changed. My father for example, taught me which plants are good for diarrhea, for the flu or any strong illness (…) but we no longer know so much about those things."[126] (Emphasis added)

People in the communities I visited appreciated having a health worker who was indigenous like them. They also appreciated having an INT that would get involved in other aspects of community life, such as attending birthday parties, joining hunting expeditions, staying over at their houses to drink *masato*[127], or advising them when outsiders –such as loggers – came into the community to negotiate the use of communal natural resources. The INTs knowledge of indigenous medicine was not something community people mentioned as an "advantage" of an INT over a *mestizo.* The INTs' friendliness was the characteristic most commonly mentioned.

Some people I spoke with would tell me "*x health worker is good because he always give us pills*", or "*so and so is not very good because he does not give us the medications we need*." Sometimes they would also evaluate health workers depending on whether they caused pain when providing an injection. One INT explained he found this amusing since usually the pain depends on the thickness of the liquid injected and whether the injection is intramuscular or not.

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[126] "Si, acá en la comunidad tenemos personas que saben curar con vegetales una mordida de víbora o una diarrea. Pero ahora se avanza y ya queremos medicamentos… ya toca. Antes no sabíamos nada, no habían ni medicamentos (…) pero ya hemos cambiado pues. Por ejemplo mi papá me ha enseñado los vegetales que son buenos para diarrea, gripe, cualquier cosa fuerte (…) pero ya no sabemos de eso tanto"

[127] See description in page 10.

Overall, it seemed that people living in the communities I visited had a narrow perception of what they could demand in regards to the services provided at a health facility. The community members had not had an opportunity to contemplate a different experience than the one they were receiving at present. Thus, their expectations about health services were not very high. None of the people I spoke with mentioned the importance of having a health worker who was familiar with their indigenous medical traditions; although many appreciated that the INTs spoke the local language. This is problematic since INTs expressed that they needed the support from the community regarding the importance of having health workers who were knowledgeable in both medical systems. This would make it easier to advocate to health authorities the relevance of their intercultural professional background. In turn, this would support the use of an intercultural health approach in all health facilities serving indigenous communities.

Although there is little overt mention of intercultural health, indigenous people still know in practice what intercultural health is. I was able to observe that the extrapolation of indigenous healing principles to Western medications was not exclusively done by INTs. Indigenous people themselves frequently combine methods, much to the surprise of health workers. In Bolognesi for example, Dr. Verónica told me she realized that indigenous people would apply Western medications in indigenous ways. She observed this in a mother's treatment of her child's *chupos*[128]. Indigenous mothers realized that a shot of antibiotic will have a fast and significant result in drying out the *chupos*. Dr. Verónica told me indigenous mothers would often come to the Health Center asking for a shot of Metamizole to heal their children's *chupos*. She remembered there was once a shortage of Metamizole, so when one mother came to get a shot

[128] Chupos is the local name used to refer to infected mosquito bites on babies and toddlers' skin, especially on their head. Chupos are a result of the child scratching the mosquito bites with dirty nails.

for her child Dr. Verónica could not give it. A week later, the same mother came back to the Health Center for another ailment and Dr. Verónica noticed a yellow powder stuck to the child's head and an improvement in the child's *chupos*. When she asked the mother what had she applied, the mother explained that since Dr. Verónica would not giver her child a shot, she bought some "Antalgina" (commercial name for Metamizole in Peru) as pills. She crushed the pills, mixed the powder with a little bit of water, made a paste which she then applied to her child's *chupos*. I remembered that I had observed this way of preparing medicinal plants among the Nahuas in Shari. They would apply boiled or crushed leaves for toothaches, headaches and stomachaches, using a different plant for each area of the body. Sometimes they used the water in which the plants had boiled (they soaked a piece of cloth and then applied it to the area in pain) and sometimes they used the plants directly over the area that was hurting. Thus, INTs and indigenous people were able to move between medical knowledges and technologies. Yet, it did not translate into having indigenous people from the communities asking or demanding that such practices became part of the standard health service provision practices in their communities.

INTs were in a way doing what many people who live in medically plural environments do: combining indigenous medical principles with biomedical ones. The difference is that they are doing it from within governmental health facilities, and after having been trained in both medical systems. The goal for AIDESEP is that the collaboration between medical systems becomes officially sanctioned by the Peruvian State. This is far from happening based on my observations. To begin with, in order for INTs to use their knowledge and familiarity of both medical systems and of indigenous ways of life, at least two changes need to occur. On the one hand, the intercultural approach should become part of the standard service provided at government health facilities, guiding the interaction between health workers and the patients and

promoting encounters where health workers would listen to indigenous people's health needs and learn about the local medical traditions. On the other hand, the health system (that includes policy-making, medical protocols, infrastructure and human resource policy) ought to incorporate intercultural approaches and become more flexible to the use of indigenous medicine. Thus, intercultural health ought to be sanctioned at both the macro and the micro levels for it to transform health service provision and address indigenous people's health needs in a culturally respectful way.

4.4 SUMMARY

As I have shown through the examples collected in the field, intercultural health can take different shapes and no definition would be able to capture all the possibilities for implementation. INTs'efforts show that sometimes intercultural health entailed using medicinal plants or other indigenous treatments at the health facility. Other times intercultural health involved combining indigenous medicine with Western medicine. In some cases this latter strategy required the participation of indigenous healers while in others it was the patient's relatives who were in charge of preparing and applying the indigenous treatments. INTs played a facilitating role in the provision of intercultural health, such as when they suggested the patient's family take the patient to an indigenous healer or when they themselves prescribed an indigenous treatment. Other times, INTs played a more active role, especially when they were the ones using indigenous principles to explain or treat an ailment.

INTs were also bridges for intercultural communication. Sometimes INTs were the ones explaining the effectiveness of indigenous medicine to non-indigenous people, and – given the

opportunity – they would demonstrate its effectiveness. They were also aadvocates for the correct use of biomedicine among indigenous people (such as when they explained the reasons for not administering antibiotic shots on a regular basis to children). Finally, they were advocates of indigenous medicine among indigenous people themselves (such was the case of Imelda for example). In their interactions with community members, INTs sometimes reminded indigenous patients that certain ailments do not require pills or injections but can be treated with plants. INTs efforts provide the basis for discussion of how the two different medical systems can interact respectfully and about the possibility that a low-scale grassroots effort can challenge the health system's current approach to provide services for indigenous people.

Knowing, understanding, respecting and using indigenous peoples' worldviews in the diagnosis, treatment and follow-up are core components of the intercultural health efforts used by INTs. They were not, however, doing this in a systematic way, nor were they documenting these activities or reporting them. This undermines the possibility for INTs and AIDESEP's PSI (if they were to focus on advocating more strongly about the importance of having intercultural workers in health facilities). It undermines how an intercultural approach where both medical systems are combined has an impact on the quality of services provided and on the health status of indigenous people. Both the MoH and AIDESEP argue that an intercultural approach improves the health care of indigenous people, but they have not been able to produce evidence for such claims. When asked why they do not document when they use indigenous medicine, INTs explained that it had not even occurred to them to do so. They would add that "there are no codes for it in the forms we have to fill out." Based on my conversations with INTs, I realized that they do not see the point of reporting their intercultural approaches. They think doctors and other health professionals at the Health Center would not care. However, the PSI (as I was told

by the advisors of the program) considered this to be a crucial step to be able to advocate for the acceptance of indigenous medicine by the MoH: The program needs to generate evidence that an intercultural approach to health is useful for reaching the national health targets set by the MoH.

Most of the examples of an intercultural approach I recorded were limited to changes at the level of health services. There were few examples when INTs tried to make more "system-level" changes. Some tried to make innovations at the health facility, such as starting a medicinal plant garden, or suggesting ways to better relate with indigenous patients.

INTs' efforts show that despite the MoH's positive rhetoric towards intercultural health, there are serious structural constraints for implementing such an approach. The workload in health facilities makes it difficult to participate in rituals associated with the preparation of indigenous treatments. On the other hand, the insurance system is based on biomedical diagnosis and there is no room to report treatments that fall outside of biomedical conventions like the successful use of medicinal plants in treating a patient. Finally, the lack of support from other health professionals makes intercultural health a hidden agenda for INTs. It is not an open effort they can promote among their co-workers.

From a policy perspective, it is fair to ask whether these experiences are replicable or not. Can health workers who are not indigenous and whose education has been exclusively in Western medicine replicate these examples of *interculturalidad* in their work place? From the indigenous organization's perspective, the question is whether INTs' isolated efforts can contribute to changing the way health services are delivered to indigenous people. A more crucial question is how much are both AIDESEP and the State "in touch" with the needs and expectations of indigenous people. The people I spoke with were concerned about the lack of medications and health workers rather than the culturally-appropriateness of the services

received. This could be the result of not knowing they have the right to receive health services that are more responsive to their cultural needs. However, in places such as the communities I visited it is also probable that medicines and services are a priority over an intercultural approach. In the conclusions, I discuss this matter in a more thorough way.

5.0 CONCLUSIONS

Debates on *interculturalidad* center on core differences in the State's understanding of *interculturalidad,* intellectuals' definitions of interculturalidad, and Latin American indigenous movements' interpretations and uses of such a concept. A similar difference occurs when it comes to intercultural health. While the MoH's official position on intercultural health claims to show openness and tolerance towards diversity, it does not seek to challenge or question the structures that have contributed to the continued marginalization of indigenous people and their medical knowledge. However, for indigenous organizations such as AIDESEP, intercultural health ought to go hand in hand with a transformative process oriented toward changing the power relations between two systems of knowledge: indigenous medical systems and the biomedical one. This, in turn, resonates with the broader efforts of indigenous organizations throughout Latin America that are questioning the historical subordination of indigenous people through the use of the concept of *interculturalidad* (Johnson 2010; Viaña 2010).

Intercultural health efforts that stem from indigenous organizations ought to be understood as part of a broader strategy to contest the terms of citizenship indigenous people have been subjected to. On the one hand, as Yashar (2005) explains, indigenous organizations are demanding equal rights (access to free governmental Primary Health Care), but on the other hand they are also demanding the recognition of special rights as native people, (such as health

services that respect their medical traditions and promote the development of indigenous medicine).

Through its Indigenous Health Program, AIDESEP has developed an educational project that aims at changing the shape of health care for indigenous people in the Peruvian Amazon. AIDESEP's intercultural health effort is rooted in the importance of strengthening indigenous people's own cultural traditions, advocating for the use of indigenous medical practices, and preparing young health professionals knowledgeable in both medical traditions. Having young indigenous people knowledgeable of both medical systems would, in turn, allow AIDESEP to establish a dialogue with the State oriented toward the transformation of health care provision for indigenous people, one from a monocultural, biomedically-based system to one that is respectful and open to indigenous medical practices.

Discussions about what interculturalidad is and what it is not; and whether it ought to be a top-down (i.e. State) initiative or a grassroots effort are interesting and stimulating. However, when studying a concrete case such as the one I have presented in this dissertation, it becomes apparent that such discussions appear detached from the concrete needs of indigenous people on the ground. The communities need timely and good quality health care. Good quality in turn, implies eliminating discrimination based on language, ethnicity and cultural practices.

By documenting INTs' everyday activities at their respective health facility, I have shown throughout this dissertation that intercultural health services are being provided in the health facilities in Atalaya where INTs are working. However, such efforts are not getting noticed, so they remain rare, isolated cases with no chance of informing policy changes or intellectual debates. Despite both the MoH and AIDESEP's position as promoters of intercultural health, INTs are conducting most of their work alone and receive no backing to ensure that the

intercultural health practices they are implementing are replicated. The possibility of transforming the way PHC is delivered in indigenous communities is thus lost.

By focusing on the experiences of INTs providing health services in indigenous communities and towns in one region of the Peruvian Amazon, I aimed to demonstrate the complexity of grounding a concept like interculturalidad in everyday health practices. Despite the increasing discursive use of interculturalidad, Sartorello (2009) explains how "interculturalidad is neither a homogeneous nor a unidirectional concept, but is itself a debated idea in constant negotiation and definition. It is not based on a foundation of shared or stable meanings, but in meanings that represent a variety of dynamic positions, both individual and collective, both official and alternative, often in conflict with each other.[129] (Sartorello 2009:78).

Interculturalidad thus cannot be seen as a position but rather as a spectrum of positions (or approaches), where some organizations stress particular aspects over others. In the case of intercultural health approaches, AIDESEP wants more radical changes in the official perception of indigenous medical systems, and thus in the interaction between medical doctors and indigenous medical specialists. AIDESEP's PSI would like to see their indigenous healers acknowledged as equally capable of solving health problems as health professionals. AIDESEP is concerned with the growing popularity of elements of Western biomedicine (due –among other things– to the increasing availability of medications in indigenous communities) at the expense of indigenous medicine.

On the other hand, the MoH wants to continue delivering health care based on biomedical principles and make some accommodations for indigenous cultural practices when necessary.

[129] A pesar de su creciente uso discursivo, la interculturalidad no es un concepto ni homogéneo ni unidireccional, sino que es en sí misma una idea debatida, en constante negociación y definición. No se sustenta en una base de significados estables ni necesariamente compartidos, sino por sentidos que representan una variedad de posiciones dinámicas, tanto individuales como colectivas, tanto oficiales como alternativas, a menudo en conflicto entre ellas.

This includes "allowing" the use of indigenous medicine. In theory, this implies ensuring that relationships between health care providers and indigenous patients are respectful so that health professionals can meet the national epidemiological goals. As I have shown in the previous chapter, health professionals in Atalaya are uninformed when it comes to official intercultural health policies and do not seek to establish a relationship with indigenous medical specialists. Furthermore, the existence of norms that promote a respectful interaction between both sets of medical specialists are widely ignored. I saw no evidence of and push on the part of the MoH to ensure health professionals who work in an indigenous area are encouraged to identify indigenous medical specialists, or expected to learn from them. There are no guidelines about how to work in collaboration with indigenous medical specialists. Overall, the MoH's vision of intercultural health does not imply a transformation from the current hierarchical relation between Western and indigenous medical systems[130].

Both AIDESEP and the MoH emphasize that two key ingredients of intercultural health should be aware that health providers are respectful of indigenous specialists and the collaboration between medical systems. Nonetheless, the complexity of such collaboration is overlooked in the Norms issued by the MoH and in the lack of support the PSI provides to INTs. As I have demonstrated in this dissertation, in practice, collaboration and the combination of medical approaches must surmount issues of power relations between those who are knowledgeable in biomedicine and in indigenous treatments. The practices must also overcome the power imbalances in the administrative structures in which health workers must operate.

INTs intercultural health efforts are thus being carried out under the radar of both AIDESEPs goals and the MoH attempts to adapt their services to indigenous people. No

[130] Yet, it is better from previous vertical approaches to health care where indigenous medicine was overlooked or openly contested.

structural transformations are taking place in health services, despite INTs' resourceful ways of providing health services using an intercultural approach. This last chapter summarizes the reasons why this is happening.

5.1 THE LIMITATION OF AIDESEPS STRATEGY: INTS WITHIN THE HEALTH SYSTEM

AIDESEP's approach to intercultural health combines efforts at rescuing, strengthening and promoting the use of indigenous medical systems by indigenous people. The political goals of AIDESEP are to have indigenous culture recognized by the Peruvian State and to protect the rights of indigenous people. In health care, the recognition of indigenous culture would imply, for instance, that public health policies acknowledge the role of indigenous healers in and promote the health needs of indigenous populations. Political and policy changes in health care for indigenous people require a dialogue with governmental institutions and in the healthcare arena. INTs could become key spokespersons for such dialogue if AIDESEP were able to provide the necessary political leverage. Unfortunately, the organization has not been able to provide the necessary political support in Atalaya or at the national level.

AIDESEP's educational program in intercultural health is based on the idea that indigenous medical systems are strengthened by having young indigenous people learning and revaluing indigenous medical knowledge and revaluating technologies in the context of a professional program. The PSI expects INTs to become professional health workers prepared to deliver much needed intercultural services in indigenous communities, where *mestizos* rarely want to work. INTs are equipped to provide the type of services the State is currently not

providing; intercultural health services that do not discriminate against indigenous people culture, where health workers are familiar with indigenous ways of life, and where the combination of medical traditions in not an exception but the norm.

The PSI expects INTs to eventually become advocates for policy changes in the health care arena. For the PSI, INTs from Atalaya should now be capable of assuming two roles: (1) improving the quality of services provided to indigenous people through the use of both indigenous and Western medicine in ways that are culturally-appropriate in the health facilities where they work; and, (2) demonstrating the effectiveness of indigenous medicine by using it and strengthening the role of indigenous healers. However, based on my research, INTS are not in the position to assume such roles, at least not yet. Their success in both roles depend on being employed in government health facilities and proving they are reliable and dependable employees within the MoH's standards.

INTs are an example of AIDESEP's interest in working with the state to address the health needs of indigenous people, yet they lack the political strength to make changes in the way health care is provided in indigenous communities using an intercultural approach. INTs' technical degree allows them to be recruited by the MoH and to legally provide services within state facilities. Given that they are hired as nurse technicians, they are expected to comply with the sector's guidelines, policies and targets. There are currently no regulations that specify that, since they hold an intercultural degree, they can use indigenous medicine at the health post or rely on referring patients to indigenous healers. This is a major setback for INTs and for AIDESEP's broader goals.

The biomedical nature of the established tasks that INTs must perform on a daily basis do not provide many opportunities for applying an intercultural approach. For instance, the health

insurance forms where INTs have to report the ailments being treated at the health post do not provide space to report indigenous treatments. In addition, most of the services that health workers end up providing (and on which their performance is evaluated) is in the realm of health care provision rather than in health promotion.

Because of their participatory nature, health promotion activities could create more opportunities to interact with the local community in their own language and on their own terms. An example of this possibility would be Javier's rounds around the community "searching" for patients. Hugo also paid visits to people in the community and Servando would leave the health post to provide care at a patient's house.

Medical care at government facilities has to follow specific medical protocols and the patient must be treated using the required allocation of pills and/or injections. These procedures are to be reported through the SIS system. If an INT decides to use an indigenous treatment or ask an indigenous healer for support, this will not be reported and the effectiveness of such treatments will go unnoticed. Similarly, if a patient comes with a culturally specific illness, and the INT treats him/her successfully, that too would go unreported because the categories do not exist on the insurance forms.

5.1.1 HIERARCHICAL RELATIONS

Besides the challenges created by the structure of health services, INTs position at their workplace also limits their intercultural efforts. Health facilities are hierarchically structured according to the education and skills of health workers. In the two Health Centers I visited, a medical doctor had been appointed as the head of the Health Center. Both doctors had recently

completed medical school and were completing their SERUM[131]. Despite that health workers with more working experience were at these facilities, these two doctors were appointed as chiefs, due to their educational background.

As nurse technicians with a three-year technical degree, INTs were at the bottom of this structure. The INTs' lower position in the health facility implied that other co-workers would ask them to do menial tasks and their opinions were not often taken into account. This situation resembles what Van Schaik (1992) found in Jamaica among Community Health Aides (CHA). Just as in the case of INTs, the training received by CHA established the boundaries of their work and defined their relationship with others in the health facility. CHA came from a poorer background than other health professionals and their medical training was less than that of other health professionals. Thus, the tasks they were assigned were those considered less important and their salaries were also less than that of other health workers.

Similarly, INTs were not only in an "inferior" position in relation to their colleagues because of their training but also because they were indigenous. INTs would be the ones asked to drive the boat when going to a community for a vaccination campaign, hang the signs outside the health post indicating that the health facility was going to be closed for a holiday, or –in the case of male INTs– carrying boxes of medications from the port to the health facility. INTs did not seem to mind collaborating in these chores, but by doing so, they were reinforcing their "inferior" position. This inferior position confines INTs and precludes them from promoting structural changes in the way health services are provided for indigenous people or to advocate for openness towards indigenous medicine. This is one of the limitations they face vis-à-vis the

[131] This Acronym stands for Servicio rural Urbano Marginal a mandatory year of service for all health professionasl after completing their undergraduate degree. It is only mandatory for those Peruvians who study a university-level health profession

expectations of AIDESEP. It is difficult to change health care provision in indigenous communities beyond the scope of their own influence.

INTs participated in a workplace culture which, as Van Schaik (1992) explains, involves not only individual acts of adaptation and accommodation but also some acts of resistance. On a daily basis, they would accommodate to the system's expectations of their work: seeing patients, monitoring the weight and growth of children under five, providing prenatal care and giving medical care. However, they would also use indigenous medicine or visit the indigenous healer to learn about his healing practices. Such activities were not in their job description despite the MoH's official position regarding its mandate to promote intercultural health.

INTs intercultural health efforts could be interpreted as acts of resistance towards the health system. Using Scott's (1985) understanding of resistance (as opposed to organized social rebellion), the hidden use of indigenous medicine is a way of avoiding direct or symbolic confrontation with authority (i.e. their coworkers with higher educational degrees). Their resistance was based on an individual act rather than a structured pattern of defiance towards biomedical health professionals. The irony is that although the MoH officially promotes intercultural health, in practice health professionals do not support it. Thus, INTs efforts to use intercultural practices in Atalaya could be considered an indirect challenge to the "establishment", rather than a contribution to health care. Despite the MoH's assertions about the importance of using interculturalidad as an approach for activities at health facilities serving indigenous populations, no concrete provisions were made for such a possibility.

INTs told me that they feared being reprimanded for openly using an intercultural approach, especially when treating patients with medicinal plants at the health facility. When INTs combined medical treatments or applied indigenous medical principles, they did so behind

the backs of their co-workers. For those working alone in a health post their strategy to keep such practices under the radar was not to report them. As a result, their efforts went unnoticed, unrecognized and ultimately ignored. The opportunities INTs might have had to introduce changes that enable the health system to "open up" to intercultural approaches to health care were lost in a way.

This situation is not particular to Peru. Lacaze (2002) for example found that despite the apparent push for the recovery of traditional medicine in the Ecuadorian health sector, there exists both a conflict and some competition between Western and traditional medicine. For this author the formal health system dominates the health sector:

> While there are proposals for coordination and collaboration, usually the formal health system tends to want to take over and this makes the chances of revealing new strategies for collaboration difficult. In large part, this conflict is caused by a power struggle. The difficulties on both sides, to overcome the limitations imposed by the ego and ethnocentrism, in turn, prevent the possibility of achieving good levels of intercultural communication based on mutual interest and respect[132]. (Lacaze D. 2002:170)

In Atalaya, biomedical health professionals I spoke with continue to view indigenous medicine as practices that are "wrong", ineffective and even dangerous to health. Only those biomedical health workers that have personal experiences with the efficacy of indigenous medicine were more open about it, but not to the extent of prescribing it.

[132] A pesar de la aparente valorización de la medicina tradicional por la medicina occidental, suele existir entre ambas una situación de conflicto y de competencia. Si bien existen propuestas de articulación y colaboración, generalmente el sistema oficial de salud tiende a querer asumir el control y esto dificulta las posibilidades de revelar nuevas estrategias de colaboración. En gran parte, esta situación de conflicto se origina por una lucha de poder. Las dificultades, en ambos lados, para superar las limitaciones que imponen el ego y etnocentrismo, a su vez, impiden la posibilidad de alcanzar buenos niveles de comunicación intercultural basados en el interés y el respeto mutuo.

5.1.2 THE MOH AND INTERCULTURALIDAD

Anthropologists have noted that it is common to find that indigenous medical systems and modern medicine are highly integrated (Young Yoon 1983). This occurs mostly at the level of the patient, who navigates a network of help-seeking that incorporates a range of alternative services (Singer, Davison et al. 1988:381). It also occurs at the level of a traditional healer, "who not only recognizes areas of competence and refers patients accordingly but also borrows without shame or apology (…) At the level of the biomedical health professional and of the health planner, however, a different pattern exists" (Singer, Davison et al. 1988:381). This different pattern is one of rejection and prejudice against traditional culture, which precludes biomedical professionals from understanding traditional therapies (Pillsbury 1979).

Without a basic understanding of the traditional practices and the value and belief systems that underpin health-related behavior, health care cannot be satisfactorily provided (Pillsbury 1979). Thus, having health professionals that have such understandings of local culture (like INTs) would result in improved health services. However, as I found in my research, having such health workers might not be enough.

Given the preeminence of biomedicine over indigenous medical systems within the MoH's structure, my research shows that integrating both medical approaches was problematic, to say the least. INTs avoided publicly discussing or sharing such intercultural activities. Examples of indigenous health workers using indigenous medicine at health facilities are not exclusive to my research. In Nicaragua, Ruiz (2006) found that Miskitu health workers called *auxiliares* practiced indigenous medicine or the *auxiliares* gave indigenous treatments to complement a physician's prescription. They also did so in a clandestine way. One of Ruiz's informants even named it "*interculturalidad escondida*" or hidden interculturalidad. This is

precisely what was occurring in Atalaya. INTs were using an intercultural approach but they were concealing it from the health system. It is paradoxical that, on the one hand, the MoH needs this kind of flexibility to address the health needs of indigenous people but, on the other, is not willing to officially recognize indigenous medicine as a partner in its efforts.

5.1.3 CULTURALLY COMPETENT HEALTH WORKERS AND THEIR ROLE IN INTERCULTURAL HEALTH

In terms of the promotion of structural changes in health care delivery, the examples of intercultural approaches used by INTs cannot be easily replicated by other health workers. AIDESEP's INTs are a very unique type of health worker. As indigenous persons themselves, they understand the basic premises of indigenous medical systems, and know indigenous understandings of health, illness and death. On the other hand, INTs have been trained and educated in both medical systems (although they are not specialists in either). They have enough biomedical training to provide primary health care in a government health facility, and INTs know enough about medicinal plants and its uses, so that they can resort to them when they see fit. They are also comfortable using indigenous explanations to engage with their indigenous patients regarding a specific ailment.

If intercultural health is –at its core – about enabling respectful interactions between both medical systems through the complementary efforts of their specialists, INTs appear to be in a privileged position to promote this interaction. However, rather than acting as brokers between two sets of medical specialists, INTs articulate two different approaches to health care. In a way, they are not building bridges but they are the bridges themselves. Under special circumstances, they either help in the negotiations between indigenous patients and Western-trained health

workers, or they refer some patients to a more knowledgeable specialist from either medical system.

The MoH's norms surrounding intercultural health have not proposed any kind of system for having an INT-like position or other intercultural specialist staffed in its health facilities. Rather, as shown in Chapter 3, the MoH's intercultural efforts appear to be focused in ensuring ways to adapt existing health services to the local culture, while following the medical protocols and providing the best biomedical health treatment available. Such an intercultural approach does not change the structural ways in which indigenous people and their culture are treated at a health facility. It also does not recognize that indigenous specialists can help them address health problems. For authors like Walsh (2009), Viaña (2010) and Tubino (2005), who argue that interculturalidad ought to be a subversive project which aims at challenging and changing the historical conditions that have maintained indigenous people in a subaltern social, political and economic position, the Peruvian' MoH's approach is only giving the impression of embracing diversity while obscuring the root causes of discrimination and exclusion of indigenous people. For authors that advocate for a critical approach to interculturalidad, [133] transforming health care ought to ensure that indigenous worldviews are taken into account in the diagnosis, treatment or prevention of illnesses. What we are seeing from the side of the MoH, is – using Walsh and Tubino's terminology – a more functional than critical interculturality, an interculturalidad that promotes the recognition of cultural diversity and inclusion both within the society and the nation-state, yet leaves aside those patterns of institutional and structural power that maintain inequality (Tubino 2005; Walsh 2010).

[133] Critical Interculturality - which questions the social model that enables discrimination towards certain cultural practices and the persistence of a hegemonic cultural system over indigenous ones (Walsh 2009:9)

Despite the idealized portrayals of an intercultural health system that appear in the MoH's norms and regulations, no provisions were made in Atalaya for health workers to learn from indigenous specialists and work together. During my interviews with *mestizo* health workers, most found such ideas about intercultural health "interesting" but could not imagine themselves working on a collaborative basis with indigenous healers. The only recognized contribution of INTs in health centers from the perspective of *mestizo* health workers was that INTs would serve as interpreters when necessary. Most of the times, when I spoke to *mestizos* about intercultural health they would understand the notion of 'intercultural' as having an interpreter at the health facility available, but not a real intellectual or systematic exchange of knowledge.

The MoH states that intercultural health is not limited to recruiting culturally competent health workers; official documents state that an intercultural approach includes having health workers promoting a respectful and collaborative interaction between the indigenous and the Western medical system (MINSA 2006). Yet, the opposite was usually happening at the health facilities I visited. Some health workers I interviewed were openly against indigenous healers who were considered "*charlatans.*" One midwife I interviewed was convinced that medicinal plants given to mothers to accelerate dilatation caused fetal suffering because the amniotic fluid emerged green[134]. From a medical standpoint, a green amniotic fluid is a sign that there was fetal distress. Dr. Documet (personal communication) explained that the amniotic fluid becomes green when the baby defecates before coming out of the womb. "The baby defecates because he/she

[134] Normal amniotic fluid is clear or tinted yellow. Fluid that looks green or brown usually means that the baby has passed his first bowel movement (meconium) while in the womb. (Usually, the baby has his first bowel movement after birth.) Source: http://www.marchofdimes.com/pregnancy/complications_amniotic.html, accessed: September 14th, 2012.

experiences fetal distress and relaxes the sphincters. If a baby aspirates liquid with meconium[135], there is a good chance that he/she gets a chemical pneumonia, which can even cause death." For the obstetrician I interviewed, herbal preparations given to indigenous mothers in Bolognesi caused fetal distress leading to defecation inside the womb.

This and other examples discussed earlier in this dissertation, show the adverse conditions (in terms of the prevalent negative perceptions of indigenous medicine) in which INTs try to become agents and advocates for indigenous medicine. As Ramirez Hita (2009) argues, most discussions around intercultural health fail to acknowledge that the interethnic relations between indigenous and non-indigenous health professionals are (and have been) conflictive and contradictory rather than harmonious and complementary.

The status of these relationships is the result of hierarchical power relations between biomedical health professionals (who are usually not indigenous) and indigenous people (Ramírez Hita 2009). Ramírez Hita points out that the differences between health professionals and the indigenous people they serve are not only cultural but also class-based. Thus, the tensions between health workers and indigenous patients occur within a context of subalternity, socio economic differences and ethnic divisions (Ramírez Hita 2009). Given that INTs are also indigenous, we cannot forget that they are working in a context where their suggestions to use indigenous medicine are considered –at best –interesting, and oftentimes amusing. In at least two cases, INTs told me that their co-workers would ask them to use indigenous medicine while using jargon such as "*brujos*" (witches), referring to INTs and "*palos*" (sticks) alluding to medicinal plants.

[135] The first stool of a newborn baby.

5.2 AIDESEP'S INTERCULTURALIDAD & BIOMEDICAL HEGEMONY

Health services in Peru are based on biomedical understandings of disease causation. As medical anthropologists have long argued, biomedicine is more than a medical system; it also symbolizes the hegemony of one system of knowledge over others. In this sense, intercultural health efforts ought to be understood as a response to a history of disdain towards indigenous medical systems. Intercultural health at its core challenges the exclusive authority of biomedical knowledge over health problems. Wayland (2003), explains, some systems are valued more than others:

> There are different types of knowledge for any given domain (e.g., aesthetic, spiritual, experiential, scientific, local). Due to historical and political processes, however, certain epistemic systems come to be valued over others and are seen as the only or the best way of understanding the world (Foucault 1970; Parpart 1995). Those who control valued knowledge are viewed as experts, and expertise often conveys authority." (p.484).

As I have shown, many of the negative opinions towards indigenous medical systems are still present in the perceptions of many *mestizos* who live in the Amazon as well as health workers and health authorities. Even some indigenous people in the communities I visited prefer Western medications to local medical treatments. The increased preference for Western medicine by indigenous people is often seen by health authorities as something positive yet, for indigenous leaders who work at the national level (such as AIDESEP's leaders), this is a negative trend. People working in AIDESEP's PSI fear that there will be a growing reliance and dependency on Western medicine while forgetting indigenous treatments that are also efficient.

When understanding the complexity of delivering intercultural health services in the Peruvian Amazon, it is important to take into account the current availability of Western medicine, as well as the symbolic asymmetry between the two medical systems. For AIDESEP, intercultural health efforts are not based on any denial of the relative benefits that Western

medicine can have on improving the health status of indigenous people. Rather, AIDESEP's position is that indigenous medicine, its practitioners and plants should have the same status as Western medicine. Indigenous medicine should be recognized by the State and thus, the practitioners of indigenous medicine ought to be given the same opportunities to provide care and continue research and development of indigenous medicine.

In the health facilities I visited, biomedical approaches to health were the norm and there were no official attempts to establish a dialogue between medical systems. Treatments provided at governmental health facilities were based on the use of pills and injections. Health workers had to follow the official medical protocols and, if a death occurred and the community was not very isolated, a medical team was sent to find out what happened and to make sure the official medical protocol was followed.

Three weeks before I arrived at Oventeni (where the Asheninka community was located), there was a maternal death[136]. A medical team was sent to investigate the events that led to such an outcome. The medical team interviewed family members, health workers and reviewed the records of the pre-natal care provided. Finally, one senior doctor interviewed the midwife and tested her on her knowledge of the basic protocols during obstetric emergencies, including terminologies and common treatments. One wonders what would have happened if the midwife said she had used a medicinal plant to stop a hemorrhage, as Javier had done in Nariteri. I wonder if – in case of death – she would have been charged with negligence. Legally, all the procedures at governmental health facilities ought to be performed by (a) a particular type of specialist and (b) credentialed personnel who follow specific biomedical procedures and

[136] Sending a medical team to investigate the causes of a person's death is not done with every death. Given that maternal mortality is a national priority and one of the Millennium Development Goals so the MoH is particularly concerned when a maternal death occurs.

treatments; leaving no officially sanctioned opportunity to practice indigenous medicine. My point is that there are no concrete legal provisions for the use of indigenous medicine at health facilities, despite the MoHs official position vis-à-vis intercultural health. The lack of clear legal frameworks to enable and/ or protect practitioners of indigenous medicine makes intercultural health an elusive strategy. This is what INTs are encountering in their everyday work.

The lack of legal regulations concerning the use of indigenous medicine at governmental facilities, together with strong governmental support for Western medicine, are two core components of the context in which INTs are working. Western medications are effective and act fast. When someone in the communities I visited had a fever, they would come to the health facility to get a Paracetamol (over-the-counter analgesic), which would reduce the fever in a couple of hours. Indigenous patients appreciate the promptness with which Western medicines work and they need such promptness. People in various communities told me that a health facility without Western medications was "no good". For instance Norberto (the INT working at the Bolognesi Health Center) remained working at the Heath Center despite being assigned to work at the Health Post located in the community of Palazo. The reason Norberto remained at the Health Center was because there were not enough medications to allot the Health Post in Palazo. Norberto and other health workers explained: "*if you arrive without medications to an indigenous community people get angry and tell you "what have you come here for?""*

When indigenous people go to the health facility, they expect to be treated with a pill or injection. They want health workers to quickly solve their health problem. In such a context, AIDESEP's demands that the State increase its access to health services for indigenous people resonates with the needs of people living in their communities. Nevertheless, as a PSI representative said in a meeting "*it is not only about getting health services and medications if*

those services are not going to be culturally respectful" (Siccar 2012). Demands for culturally respectful health services was not a demand I heard being made by indigenous people living in the communities I visited. However, people told me on several occasions they were grateful for having a health worker who was indigenous and who could understand the local explanations of disease. One way of interpreting such situations is that governmental health services where both medical traditions are respected and available is something people at the grassroots level cannot imagine given that they associate Health Posts with Western medicines. As Ramirez Hita points out in her study at the Tiquipaya Hospital in Bolivia, going to the health facility to get the services from indigenous healers is a foreign idea for indigenous people. In her study, when indigenous patients chose to go to a health facility, it was because they wanted to receive biomedical treatment (Ramírez Hita 2009).

AIDESEP's efforts to implement intercultural health services for indigenous people is part of a broader struggle around the rights of indigenous people to other ways of thinking about democratic practices and cultural difference. The fact that people living in indigenous communities are not pushing for intercultural health services should not be interpreted as a disconnection between indigenous leaders of national organizations and indigenous people at the grassroots. This can also be attributed to how there is limited information available for indigenous people regarding their rights to have health services that are appropriate to their social and cultural contexts. Further research on indigenous grassroots efforts around intercultural health could study the relationship between indigenous demands for intercultural approaches in public policies and the basic needs of indigenous people.

5.3 PROMOTING USE OF INDIGENOUS MEDICAL KNOWLEDGE

Most of the examples of intercultural health that I documented in the field constitute examples in which indigenous medicine was used at the health facility, either independently or in combination with Western medicine. This was not done openly nor were indigenous practices accounted for because the structure of health services is strict and revolves around a biomedical paradigm. I realized that the lack of flexibility on the part of the health system prevented the creation of spaces where it would be possible to interact with other medical knowledges and practices.

5.3.1 THE CHALLENGE OF SWIMMING AGAINST THE TIDE

AIDESEP's aim is to have indigenous medical knowledge recognized as important and useful, independently or in combination with Western medicine, to address certain health needs of the population. This position is sometimes seen as just a political tool to demand from the Peruvian State a greater acceptance of indigenous culture. In Atalaya, where indigenous organizations are politically strong, health needs have not yet been capitalized as political tools and INTs' efforts are quite independent of the local indigenous organizations (Rodriguez Torres, Valdez Felipe et al. 2009).

Currently, INTs efforts only occur at the level of interpersonal relations, what Albó (2002) calls *micro* interculturalidad[137]. INT's efforts are not complemented with changes at the

[137] See section 2.2.2 for a detailed explanation of this concept.

level of social and symbolic structures which, for example, would imply an official recognition of the use of indigenous medical treatments in PHC facilities.

Ideally, *micro* interculturalidad could lead to *macro* interculturalidad but AIDESEP does not necessarily express it in those terms. AIDESEP's position vis-à-vis interculturalidad in health care is somewhere in between *micro* and *macro* interculturalidad. AIDESEP wants an improvement in the quality of health services provided to indigenous people, but they also aim at having indigenous medical traditions accepted, acknowledged and recognized.

At the micro level, interculturalidad in healthcare is not limited to having health workers who respect the "cultural" traditions of indigenous people. Intercultural health services imply treating indigenous people with respect. The observations and conversations throughout my fieldwork point to the existence of a close relationship between communities and INTs. The health post is often a place where people congregate to chat, watch videos at night, or hold community meetings. Having indigenous people providing services at health facilities has been done in other countries, and it has been demonstrated to lead to improvement in the quality of the service (Ruiz 2006). Nevertheless, it seems that health workers have experienced similar problems as the INTs discussed here when trying to use an intercultural approach. It is necessary to practice an intercultural approach out of sight. The clandestine use of indigenous medicine by INTs was also observed by Ruiz (2006) in Nicaragua. My findings coincide with Ruiz's in that "[i]ndividuals working in the health system still have ambiguous feelings about the acceptance of indigenous medicine, despite the rhetoric of "openness" and "acceptance" in the health system…" (Ruiz 2006:234).

INTs are enabling the co-existence of both medical systems, whether by combining the two approaches or by seeking indigenous healers to see a patient. This is, however, not enough to

change the way the health system works (policy-making, medicine allocation, and overall acceptance of indigenous medicine), or to obtain the recognition that indigenous medical traditions are efficient and valid. Thus, AIDESEP's intercultural goals in the health realm are not acknowledged, nor disseminated as examples of intercultural health. Health workers perceive that INTs are merely interpreters and useful because they perform the more menial tasks that are necessary in a health facility. This reproduces hierarchical differences along ethnic and class lines.

Despite the norms and regulations concerning intercultural health issued by the Peruvian MoH there is still ambiguity among health officials regarding intercultural health. In 2011, I interviewed Dr. Oswaldo Salaverry, Director of the CENSI. I narrated some of the INTs intercultural health efforts I had recorded during my fieldwork, trying to show him that changes can be introduced at the PHC level. He told me that the problem with the way the INTs were implementing intercultural health practices was that they were "not structured." He then explained that any state policy had to establish guidelines about intercultural health and how to implement it. He implied that the state cannot "allow" people to apply interculturalidad as they wish. Dr. Salaverry's position reflects the shape the MoH would like interculturalidad to have. Interculturalidad should be a set of practices that results in activities and indicators that can be measured. This goes against the premise that intercultural health is about providing the flexibility to adapt the services to the local context.

In a conversation in 2011 with workers at the NGO "Salud Sin Limites," an NGO that has implemented intercultural health projects in the Andean and Amazonian regions of Peru, NGO workers told me they believe that the MoH still has concerns about possible negative interactions between indigenous and Western medicine. They explained that some health

workers worry that allowing for the legitimacy of both types of medicine might endanger the patient's life. Thus, it is unlikely the MoH will take the risk of establishing legal guidelines that allow indigenous medicine to be used by health workers within health facilities, as INTs are now doing. There are legal consequences for health workers when patients die out of negligence and State officials are concerned that without "scientific" studies about indigenous treatments, promoting their use can have negative impacts on a patient's health. This is similar to what the WHO was arguing back in 1978 when it stated that States should "study the potential usefulness of traditional medicine including evaluation of practices and examination of the safety and efficacy of remedies to upgrade the knowledge of traditional and modern health practitioners" before incorporating traditional medicine into national health systems (WHO 1978). Biomedicine is the framework against which indigenous medicine is compared and evaluated. The concerns about the potential negative interactions between indigenous medicine and biomedicine are not only present among health authorities. Health workers themselves have apprehensions as in the example I provided in Chapter 3 regarding the health worker who decided against administering antibiotics to a patient who told him she had consumed a medicinal plant before coming to the health post.

5.3.2 NEGATIVE STEREOTYPES

The intercultural health approach currently being implemented by INTs in Atalaya's health facilities represents a small-scale effort with limited impact in the way the health system operates and interacts with indigenous people. Following Albo's definitions, no macro-level changes are occurring. The structural causes for discrimination of indigenous people are not being subverted and questioned (as a critical approach to interculturalidad demands). However,

there are other components of interculturalidad that are taking place. For instance, INTs efforts are based on specific kinds of social interactions, crucial for an intercultural approach: openness to dialogue, adaptation of services, and acceptance of indigenous medicine. For these efforts to be replicated on a larger scale, the first step would be to discuss openly the discrimination and contempt health workers often have towards indigenous people and their culture.

Misconceptions about indigenous medicine go hand in hand with perceptions of indigenous people as less intelligent. Such stereotypes, I found, were still present among health authorities and the *mestizo* population. Alluding to what he believed was the diminished intellectual capacity of the Nahuas, a medical doctor in Sepahua said to me: "*Tell me, since you are an anthropologist, how much do you think their brain weighs*?"[138] The irony was that this medical doctor was particularly concerned about ensuring the Nahuas had access to health services. Juan Reátegui from the PSI told me that a health authority in Atalaya once also made a joke that was in bad taste: "*What is the only difference between a dog and an Ashaninka? That Ashaninkas can speak.*"[139] In Bolognesi, the physician told me that some *mestizos* from the community were willing to pay her to give them medical attention instead of the INT. They told her they did not trust Norberto because he was indigenous. In a conversation about an INT who used to drink on a regular basis, a colleague added "*That's the way they are, they like drinking*"[140], essentializing indigenous people as drunkards.

Despite these negative stereotypes, none of the INTs said they were ashamed of indigenous medicine. That was not the reason to avoid openly practicing an intercultural approach. Hiding their practice of indigenous medicine was more of a strategy to avoid problems

[138] A ver tú que eres antropóloga… cuánto crees que pesa el cerebro de un Nahua?
[139] ¿Sabes cuál es la única diferencia entre un perro y un asháninka? Que los asháninkas saben hablar.
[140] Así son "ellos", les gusta tomar.

with their colleagues. In the interviews I held with INTs in 2008, 2010 and 2011 the INTs were all proud of indigenous medicine. They were assertive when explaining to me that all Western medications come from medicinal plants, and that both medicinal plants and Western medications were effective, just processed and presented in a different way.

Indigenous people from the communities I visited also used both sets of medicines but relied more on Western medicine. They were aware of the poor reputation of medicinal plants among health professionals and told me they avoided telling the doctor, nurse or any health worker that they had previously visited a *sherpiari* or *curandero* or that they had drank some *piri piri.*

For Singer and Davidson (1988) the tendency to discount the ideas and understandings of indigenous patients as irrational, backward and irrelevant appears to be based on the assumption "that indigenous health beliefs are static and stagnant and hence inherently in conflict with a medical system alleged to be founded on the scientific principles of empirical verification and accumulated knowledge" (p.381). Demonstrating the ways in which indigenous healers learn and improve their medical practices has been shown to influence the way in which health professionals think about indigenous medicine (Mngqundaniso and Peltzer 2008). Actually, during my fieldwork, those *mestizo* health workers who have worked for several years among indigenous people and who have had the opportunity to witness healing practices used by indigenous healers, did not have a problem in acknowledging in our conversations that indigenous medicine was also effective.

The disregard towards indigenous medicine on the part of *mestizo* health professionals in Atalaya was, however, the norm. Indigenous people did not share their medical decisions openly and willingly with health professionals. Medical decisions, Crandon (1991) argues, are

embedded in a complex network of historically produced social relations amongst groups. According to Crandon, the type of medicine people in a small Bolivian town chose provided information about their social position and ethnicity (Crandon 1991). Indigenous people who aimed to develop relations with *mestizos* avoided admitting their preference for indigenous medicine. Similarly, Cunningham (2002) found that some indigenous people in Nicaragua were ashamed of acknowledging they used medicinal plants since such use was associated with backwardness and savagery. The new generations of indigenous people in Nicaragua grew up as *mestizos* (their parents did not teach them their indigenous language and would dress them in Western clothes, etc). This is similar to what is occurring among indigenous people in Atalaya.

Intercultural health efforts proposed by the MoH in Peru as well as AIDESEP fail to provide concrete elements to apply interculturalidad to social policy. As I have shown in this dissertation, AIDESEP's project failed to consider that without structural support, it would be difficult to incorporate an intercultural approach in the MoH. INTs receive no incentives or recognition for promoting the joint work of indigenous and Western medicine. INTs also face several challenges in trying to use indigenous medicine. The work of the INTs provides an example of an intercultural approach that does not attempt to undermine biomedicine but rather highlights that indigenous medicine also has the capacity to address health problems.

Interculturalidad at its core requires the capacity to establish horizontal and open dialogue between health workers and community members. INTs have managed to take steps in that direction, probably because the INTs are also indigenous and in most cases belong to the same ethnic group as the people they serve. Ruiz's (2006) observations during his fieldwork in Nicaragua among the Miskito Indians showed a similar situation in which having people from

their own ethnic background made the relationship between the community and the health worker closer and more prone to using an intercultural approach.

5.3.3 INDIGENOUS LEADERS, INDIGENOUS PEOPLE AND FUTURE STUDIES

Although not the central topic of this dissertation, it became apparent that AIDESEP's push for intercultural health does not necessarily reflect the aspirations of indigenous people in terms of health care provision in Atalaya. Indigenous people I spoke with in the five field sites wanted improved health services, but this improvement did not consist in the use of an intercultural approach by health workers. The improvements highly valued were permanent staffing, availability of medications and extended hours of operation of health facilities.

While other studies have focused on the political use of interculturalidad by indigenous organizations (Ruiz 2006), my focus was on the shape of the intercultural health efforts promoted by an indigenous organization in the Peruvian Amazon. I considered the possibilities of implementing such a program and the limitations against eventually scaling up such efforts. For ADIESEP, the training of INTs represents a first step towards providing indigenous people with culturally-appropriate health care. However, such initial efforts appear to have a limited impact because indigenous people in the communities they serve do not demand an intercultural approach to health and as such, are not currently supporting it (but neither are they opposing it).

Except for some indigenous leaders (community chiefs or political leaders of regional indigenous organizations), it was rare to find an indigenous person in the community advocating strongly for the recovery of their medical systems during my research. While indigenous leaders in AIDESEP have broader political goals in the promotion of intercultural health, INTs had

concrete goals of serving indigenous people as best as they could and indigenous people wanted their health needs addressed.

In this sense, a future study should be oriented towards furthering the apparent disconnection between indigenous leaders' discursive efforts surrounding intercultural health efforts and indigenous people's expectations around health services. One of the possible explanations is that AIDESEP is going through a crisis of representation where many local federations accuse AIDESEP leaders of financial mismanagement and they are no longer respected as good leaders (Yashar 2005).

On the other hand, the disconnection between the efforts promoted by AIDESEP at the national level and indigenous peoples' demands in regards to health services may have to do with indigenous communities' perceptions of governmental health services (as a favor more than a right) and the limited access they usually have available to them. Most indigenous people I spoke with were satisfied with the basic services they were receiving. For some of the communities I visited, the current health facility was their first experience with a permanent health facility offering free governmental health care. This certainly influenced the expectations people living in the visited communities had of such services. People in the visited communities did complain about the lack of medications but would not articulate more complex demands regarding the services they received.

In most of the field sites visited, I observed how communities were quite vulnerable vis-à-vis state health services. Their members rarely voiced concerns about the services they were receiving or rarely took a critical stance towards it. Each community or each indigenous group had a different experience with Western medicine and the historic process by which Western medicine was introduced in their territories. Sometimes it was done by missionaries, others by

the state and yet others by extractive industries that enter the area. These past experiences –I believe– shape their current perceptions and expectations about governmental health services.

Applied research projects could further the results of my dissertation. Throughout my fieldwork and while I was writing this dissertation, I stayed involved with AIDESEP's PSI. The information I collected has been discussed in conversations about future projects. One issue that came up is the need to record the impact that projects like the PSI are having on the health of the population they serve. If AIDESEP wants to be recognized by the MoH, it needs to demonstrate that INTs strategies have an impact on reducing health indicators that are crucial to the country such as maternal, neonatal, and childhood mortality, infectious diseases and sexually transmitted diseases, to name a few.

Finally, it would be important to study the way in which mestizo health workers change their views about indigenous medicine. I saw glimpses of this process but if researched in a systematic way, it could provide the basis to rethink cultural competence and the process by which it is acquired.

APPENDIX A: INTERVIEW QUESTIONNAIRE FOR COMMUNITY MEMBERS

1. What are the main health problems you see in the community?
2. What are the services people usually go to the health post for?
3. For what kind of illnesses do people use home remedies or go to an indigenous healer?
4. Can you provide an example?
5. What are the factors people take into account when deciding to take a sick relative to see an indigenous healer or to the health post?
6. What are the main differences between the services provided by indigenous healers and the services provided at the health post?
7. Have you visited the health post? **(no need to tell me why you went)**
8. What is the role of the Intercultural Health Technician (IHT)?
9. Have you observed any visible changes in the services provided at the health post since the IHT arrived in the community? Can you give me examples?
10. What is the relationship between the health worker and the intercultural health technician?
11. Have you used traditional medicine for your health problems? **(no need to tell me what health problem)**
12. Is there a relationship between indigenous healers and health workers?
13. Do you think the presence of IHTs have influenced this relationship?
14. How do you think health workers view indigenous medical practices?
15. Do you remember a situation in which an indigenous healer worked together with a health worker to help someone get better?
16. Do you think it is possible that health workers will eventually recognize indigenous medicine as equally important as biomedicine?

17. What do you think is the role of intercultural health technicians in the effort to bring together these two medical systems?

18. Do you think health workers are slowly accepting indigenous medical practices? Could you explain your answer?

19. What do you hope to see at the health post in your community? Why?

Thank you!

Cuestionario para personas de la comunidad

1. ¿Cuáles son los principales problemas de salud en la comunidad?
2. ¿Cuáles son los servicios de salud a los cuales las personas usualmente van?
3. ¿Para qué tipo de enfermedades la gente va a ver al médico indígena o usa remedios caseros?
4. ¿Me puedes dar un ejemplo?
5. ¿Qué factores toma en cuenta la gente cuando tiene que decidir entre llevar a un familiar enfermo a la posta de salud o a donde un médico indígena?
6. ¿Cuáles diría usted que son las principales diferencias entre los servicios que usted le da a la gente y los que ellos reciben en la posta de salud?
7. ¿Has ido a la posta de salud? **(no es necesario que me digas el motivo por el cual fuiste)**
8. ¿Cuál es el rol de los técnicos de salud intercultural en la comunidad?
9. ¿Ha observado algún cambio evidente en los servicios de salud desde que el TSI llego a la comunidad? ¿Me puede dar algunos ejemplos?
10. ¿Cuál es la relación entre los trabajadores de salud y los técnicos de salud intercultural? ¿Cómo la describirlas?

11. ¿Has usado medicina tradicional para curarte de alguna enfermedad? **(no es necesario que me digas cual enfermedad)**

12. ¿Existe alguna relación entre los trabajadores de salud y los médicos indígenas?

13. ¿Piensas que los TSI han influenciado la relación que existe entre los trabajadores de salud y los médicos indígenas?

14. ¿Usted piensa que los trabajadores de salud están aceptando progresivamente las practicas medicas indígenas? Me podría explicar su respuesta?

15. ¿Recuerda alguna situación en la que trabajo junto con un trabajador de salud para ayudar a alguien?

16. ¿usted cree que es posible que eventualmente los trabajadores de salud reconozcan a la medicina indígena igual de importante que la medicina occidental? ¿Me puede explicar su respuesta?

17. ¿Cual cree que es el rol de los técnicos de salud intercultural en el esfuerzo para que los dos sistemas médicos trabajen juntos?

18. ¿Usted piensa que los trabajadores de salud van a aceptar eventualmente las practicas medicas indígenas? ¿me podría explicar su respuesta?

19. ¿Cómo te gustaría que sean los servicios de salud en la posta en el futuro? ¿Por qué?

¡Gracias!

APPENDIX B: INTERVIEW QUESTIONNAIRE FOR INDIGENOUS HEALERS

- What is your area of expertise? What do people usually come to you for?
- How long ago did you start healing others? How did it all started?
- Do people from other communities come to see you?
- What are the main health problems you see in the community?
- What are the services people usually go to the health post for?
- What is the relationship between the health worker and the intercultural health technician?
- Have you observed any visible changes in the services provided at the health post since the IHT arrived in the community? Can you give me examples?
- What are the main differences between the services you provide and the services provided at the health post?
- What is your opinion of Western medicine in terms of its importance for indigenous peoples' health?
- How will you describe your relationship with health workers?
- Do you remember a situation in which you worked together with a health worker to help someone get better?
- Do you think it is possible that health workers will eventually recognize indigenous medicine as equally important as biomedicine? Could you explain your answer?
- What are the main challenges in developing collaborative relations with health workers?
- What do you think is the role of intercultural health technicians in the effort to bring together these two medical systems?
- Do you think health workers are slowly accepting indigenous medical practices? Could you explain your answer?

Guía de Entrevista Médicos Indígenas

- ¿En que se especializa usted? Para que viene la gente a verlo?
- ¿Hace cuánto tiempo que usted se dedica a curar a otros? ¿Se acuerda cómo empezó? ¿Hace cuantos años?
- ¿Vienen a verlo personas de otras comunidades? Se acuerda de alguno caso?
- ¿Cuáles son los principales problemas de salud en la comunidad?
- ¿Cuáles son los servicios de salud a los cuales las personas usualmente van?
- ¿Cuál es la relación entre los trabajadores de salud y los técnicos de salud intercultural? ¿Cómo la describirlas?
- ¿Ha observado algún cambio evidente en los servicios de salud desde que el TSI llego a la comunidad? ¿Me puede dar algunos ejemplos?
- ¿Cuáles diría usted que son las principales diferencias entre los servicios que usted le da a la gente y los que ellos reciben en la posta de salud?
- ¿Qué opina usted de la medicina occidental en términos de su importancia para la salud de los pueblos indígenas?
- ¿Cómo describiría usted su relación con los trabajadores de salud?
- ¿Recuerda alguna situación en la que trabajo junto con un trabajador de salud para ayudar a alguien?
- ¿usted cree que es posible que eventualmente los trabajadores de salud reconozcan a la medicina indígena igual de importante que la medicina occidental? Me puede explicar su respuesta?
- ¿Cuáles son los principales retos para desarrollar relaciones de colaboración con los trabajadores de salud?
- ¿Cuál cree que es el rol de los técnicos de salud intercultural en el esfuerzo para que los dos sistemas médicos trabajen juntos?
- ¿Usted piensa que los trabajadores de salud están aceptando progresivamente las prácticas médicas indígenas? Me podría explicar su respuesta?

APPENDIX C: INTERVIEW QUESTIONNAIRE FOR HEALTH WORKERS

1. How old are you?
2. Where are you from?
3. How long have you been working in this community?
4. How did you get assigned here?
5. What is the most important experience you have had since you started working at this community?
6. Had you worked in an indigenous community before? How was that experience?
7. What is the main challenge that health professionals encounter when working in indigenous communities?
8. How does your experience providing services for indigenous people been affected by the presence of an IHT working side-by-side you?
9. How did you decide to study to become a health technician?
10. What where the main factors you took into consideration when making that decision?
11. Where did you study? (City and name of institution) Did you have family there or you had to move from somewhere else to pursue your career?
12. What do you remember of your years studying to become a health technician?
13. What where the main challenges you encountered in your career while you were a student?
14. Do you remember any experience in particular?
15. As a student at (name of institution) do you remember any of your professors talking about traditional medicine? What do you remember?
16. When you hear the term “traditional medicine” what do you think of?
17. What would you say are the differences between “traditional medicine” and “Western medicine”?
18. What would you say are the similarities between “traditional medicine” and “Western medicine”?
19. Do you think the idea of having intercultural health services is possible? What do you think it entails?

20. Do you think you would have liked to learn some traditional medicine practices and principles when you were studying to become a health professional? Why?
21. Do you think others studying to get a health degree would like to learn some traditional medicine practices and principles? Why?
22. Indigenous peoples are now advocating for the recognition of their knowledge and practices as important for their own development, what do you think about these ideas and this process?
23. How is your relationship with the Intercultural Health Technician?
24. Are there any changes that he/she has advocated since she/he started working at the health post?
25. What would you say is their main contribution to the services you provide?
26. Regarding the community's health: What are the most frequent health problems?
27. Are there any other medical options besides the services you provide?
28. Do you know the different traditional healers in the area?
29. How do you know about them? What do you think about their medical practices?
30. Have you ever worked together with any of them? Can you explain to me how was this experience?

Thanks for your time!

Guía de Entrevista a Trabajadores de Salud

1. ¿Cuántos años tienes?
2. ¿Dónde naciste?
3. ¿Hace cuánto tiempo estás trabajando en esta comunidad?
4. ¿Cómo te asignaron a trabajar acá?
5. ¿Cuál es la experiencia más importante que has tenido desde que empezaste a trabajar en esta comunidad?
6. ¿Habías trabajado en una comunidad indígena antes? ¿Cómo fue esa experiencia
7. ¿Cuál consideras que es el principal reto para los trabajadores de salud que son enviados a trabajar en comunidades indígenas?
8. ¿Cómo piensas que tu experiencia ofreciendo servicios de salud para indígenas ha cambiado a raíz de la presencia del técnico de salud intercultural contigo en la posta?
9. ¿Cómo decidiste estudiar para ser técnico en enfermería?
10. ¿Qué factores recuerdas haber tomado en cuenta cuando decidiste seguir esa carrera?

11. ¿Dónde estudiaste? (ciudad y nombre de la institución) ¿Tenias familia allí o te tuviste que mudar de donde vivías para seguir esta carrera?
12. ¿Qué es lo que más recuerdas de tus años estudiando para ser enfermero?
13. ¿cuáles fueron los principales retos que enfrentaste mientras estudiabas?
14. ¿Recuerdas alguna experiencia en particular?
15. Como estudiante de (nombre del instituto) ¿recuerdas si alguno de tus profesores hablaron en clase sobre medicina tradicional? ¿Qué recuerdas?
16. ¿En qué piensas cuando escuchas el término "medicina tradicional"?
17. ¿Cuáles dirías tú que son las principales diferencias entre la medicina tradicional y la medicina occidental?
18. ¿Cuáles dirías que son las similitudes entre la medicina tradicional y la medicina occidental?
19. ¿Qué piensas de la idea de ofrecer servicios de salud interculturales? ¿es posible? ¿Qué piensas que estos servicios implican?
20. ¿Piensas que te hubiera gustado aprender algunas prácticas y principios de la medicina tradicional cuando estudiabas para ser un trabajador de salud? ¿Por qué?
21. ¿Piensas que a las personas que están actualmente estudiando para ser profesionales en salud les interesa aprender algunas prácticas y principios de la medicina tradicional? ¿Por qué?
22. Los pueblos indígenas están actualmente luchando por el reconocimiento del conocimiento y las practicas indígenas como un elemento importante de su desarrollo… ¿Qué piensas de estas ideas y de este proceso?
23. ¿Cómo es tu relación con el técnico de salud intercultural?
24. ¿Hay algunos cambios que él/ella han promovido en la posta desde que empezó a trabajar en la posta de salud?
25. ¿Cuál dirías que es la contribución más importante de los TSI a los servicios que se dan en la posta?
26. En cuanto a la salud en la comunidad: cuales son los problemas de salud más comunes?
27. ¿Además de los servicios de salud de la posta, que otras opciones medicas tienen las personas?
28. ¿Conoces a los médicos indígenas en la comunidad?
29. ¿Cómo sabes acerca de ellos? ¿Qué piensas sobre sus prácticas médicas?
30. ¿Alguna vez has trabajado con alguno de ellos? ¿Me puedes contar como fue esta experiencia?

Gracias por tu tiempo

APPENDIX D: INTERVIEW QUESTIONNAIRE FOR INTERCULTURAL NURSE TECHNCIANS (2010)

1. What does your work at the health post entails? How does a workday looks like for you?
2. How long have you been working at the health post?
3. How is the work that you do different or similar to what you were expecting after graduating as an intercultural health technician?
4. What changes have you promoted in the services provided at the health post?
5. What are the things you enjoy the most of working at the health post? Why?
6. What are the main challenges you experience as an intercultural health technician? Elaborate.
7. What are the main health problems that people have in the community?
8. How do they usually address these health problems?
9. How is the relationship between health workers and indigenous healers?
10. Could you give an example of a situation in which health workers and indigenous healers worked together and what happened?
11. What is your relationship with indigenous healers? Do you work with them sometimes?
12. What changes have you promoted in the services that are currently provided in the health post?
13. Can you tell me about the process of introducing those changes?
14. How will you describe your relationship with the heath worker?
15. Do you think the health worker accepts and respects indigenous medicine? Can you explain your answer?

16. What are the kind of things you think you still need to advocate for in term of health services?

17. Have your opinions about indigenous medicine changed since you started working?

18. Have your opinions about Western medicine changed since you started working?

19. What are the most important things that need to change in order to address indigenous peoples' health needs?

20. What is the role of the indigenous organization in this process?

Thanks for your time!

Guía de Enterevista Técnicos de Salud Intercultural

1. ¿En qué consiste tu trabajo en la posta de salud? ¿Cómo es uno de tus días de trabajo?

2. ¿Hace cuánto tiempo estás trabajando en esta posta de salud?

3. ¿En que se parece o se diferencia el trabajo que estás haciendo con lo que esperabas hacer cuando estabas estudiando para ser un técnico de salud intercultural?

4. Que cambios has promovido en los servicios de salud para que sean más interculturales?

5. ¿Qué es lo que más te gusta de tu trabajo en la posta de salud? ¿Por qué?

6. ¿Cuáles son los principales retos de tu experiencia como técnico de salud intercultural? ¿puedes elaborar tu respuesta?

7. ¿Cuáles son los principales problemas de salud en la comunidad?

8. ¿Cómo usualmente resuelve la gente estos problemas?

9. ¿Cómo es la relación entre los trabajadores de salud y los médicos indígenas?

10. ¿Me podrías dar un ejemplo en el que pudiste ver como los trabajadores de salud y los médicos indígenas trabajaron juntos?

11. ¿Cómo es tu relación con los médicos indígenas? ¿a veces trabajas con ellos?

12. ¿Qué cambios has promovido en los servicios de salud que se ofrecen en la posta?

13. ¿Me podrías contar como ha sido el proceso de promover esos cambios?

14. ¿Cómo describirías tu relación con el trabajador de salud?

15. ¿Piensas que los trabajadores de salud aceptan y respetan la medicina indígena? ¿Me podrías explicar tu respuesta?

16. ¿Cuáles son las cosas que todavía sientes que puedes cambiar en los servicios de salud?

17. ¿Han cambiado tus opiniones sobre la medicina indígena desde que llegaste?

18. ¿Han cambiado tus opiniones sobre la medicina occidental desde que llegaste?

19. ¿Cuáles son las cosas más importantes que piensas que deben de cambiar para poder mejorar la situación de salud de los pueblos indígenas?

20. ¿Cuál piensas que es el rol de la organización indígena en este proceso?

¡Gracias por tu tiempo!

APPENDIX E: GUIA DE ENTREVISTA PARA TECNICOS DE SALUD INTERCULTURAL (2008)

1. ¿Cómo te enteraste del proyecto? ¿Qué es lo que te animó a participar?
2. ¿Ya antes tenías algún tipo de interés o experiencia en temas de salud? ¿Cuál/cómo así?
3. ¿Cuáles fueron las principales dificultades que encontraste en la etapa de formación como TSI? ¿cómo las superaste?
4. ¿cómo sientes que participar en el proyecto ha cambiado tu forma de ver las costumbres de tu pueblo? (pedir ejemplo)
5. ¿cómo te ha ayudado comprender la cosmovisión de tu pueblo?
6. Si tuvieses la oportunidad de cambiar algo en el proyecto, ¿qué cambiarías?
7. ¿cuál es para ti la principal diferencia entre la medicina occidental y la medicina indígena? (pedir ejemplo)
8. ¿cuál es para ti las principales semejanzas entre la medicina occidental y la medicina indígena? (pedir ejemplo.)
9. ¿cuál sientes q es la ventaja de que hayan jóvenes indígenas capacitados en ambos sistemas médicos sobre los enfermeros que sólo manejan el sistema occidental?
10. ¿cuál crees que es la importancia para los pueblos indígenas de que hayan técnicos de salud intercultural como tú y tus compañeros?
11. ¿qué sientes que es lo más difícil de trabajar como técnico de salud intercultural?
12. Me podrías contar alguna experiencia que te ha marcado hasta ahora en tu trabajo en la posta de salud.
13. ¿Cómo te han servido los conocimientos y tecnologías de ambas medicinas en la atención de tus pacientes?
14. ¿cuál piensas que es el rol de la organización indígena en promover este tipo de servicios?
15. ¿Cuál piensas que es el rol del MINSA?
16. ¿Cómo sientes que tú como profesional puedes ayudar en el desarrollo de tu pueblo o comunidad?

Muchas Gracias

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