Intercultural Health in Ecuador:
A Critical Evaluation of the Case for Affirmative Biopolitics

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This research examines the prospect of affirmative biopolitics through Intercultural Health policies in Ecuador. Spurred by radical demands for decolonization by the indigenous movement, Interculturality became a political platform for the recognition of indigenous groups and alternate forms of development such as *Sumak Kawsay* and *Buen Vivir* during the administration of President Correa. Part of expansive healthcare reforms, Intercultural Health policies attempted to recognize traditional indigenous medicines within the public universal healthcare system. Based on ethnographic research at a Ministry of Public Health clinic housing indigenous midwives and biomedical practitioners, I examine the biopolitical implications of enacting Interculturality through national healthcare policies.

I argue Intercultural Health policies provide a critical case study for a nuanced theory of affirmative biopolitics. Through detailed examination of policy in-action, I examine the complex negotiations behind adjusting biopolitical agendas to include diverse ways of life. Building upon proposals for affirmative biopolitics, I propose an analytical framework for examining how biopolitical agendas can incorporate diverse ways of life. I argue that affirmative biopolitics are defined by a plurality of lifeways, networks of change, participatory governance, and political and structural adjustment. Through my analysis of Intercultural Health policies, I demonstrate how these components interact in complex ways to both support and undermine affirmative biopolitical goals. In doing so, I argue against theorizing biopower as predominantly neoliberal or as a monolithic agenda of the state. I demonstrate how Ecuadorian neo-socialist policies established a co-responsibility between citizens, communities, and the state. Likewise, activist and indigenous involvement in political structures creates challenges from within state institutions. Ultimately, biopolitical controls limit radical paradigms to incremental affirmative change.

Across multiple levels of policy design and implementation, I analyze the frictions between the hegemonic forces of biopolitical agendas such as the *Buen Vivir* objectives, and expanding the biolegitimacy of diverse ways of life through Interculturality. Despite attempts to incorporate traditional medicines, the push to achieve statistical health outcomes ultimately reinforced the dominance of biomedicine. At all levels, individuals questioned what forms of inclusion are truly legitimizing. However, instead of resisting biopolitical control outright, many sought more inclusive forms of biopower.

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Dedication

For Sofía, who taught me how to be an advocate.
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1.0 Introduction

The purpose of this research is to examine the biopolitical implications of Intercultural Health policies in Ecuador. I analyze the critical case study of Interculturality and *Buen Vivir* proposed by the indigenous movement and adopted by President Rafael Correa to propose a nuanced framework of affirmative biopolitics that attempt to promote (rather than discourage) multiple ways of life. In particular, I focus on the design and implementation of Intercultural Health policies aimed at promoting and incorporating traditional indigenous medicines in the national healthcare system. As part of broader efforts to incorporate indigeneity in national institutions, Intercultural Health policies were an explicit strategy for broadening state definitions of biocitizenship and national belonging. However, the impact of Intercultural Health policies on establishing institutionalized medical pluralism and transforming the biopolitical agendas of the state are complicated by the varied perspectives of stakeholders, and the inherent inequalities of the existing structures upon which they build. Drawing on this case study, I argue for a nuanced understanding of biopower as both a source of affirmative power and social control. In doing so, I examine the inherent frictions between multi-nodal calls for change towards participatory democracy and politics of recognition, and the boundaries and exclusions inherent in mechanisms of biopolitical surveillance and enforcement.

Ecuador is an appropriate case study for examining Intercultural Health and affirmative biopolitical analysis because of the extent to which radical political demands of the indigenous rights movement were incorporated in national policy during the administration of President Rafael Correa (2007-2017). Not only were demands for the universal right to health and revitalization of traditional indigenous medicines enshrined in the constitution (ratified in 2008), but the national development agenda was redefined based on indigenous models of holistic wellbeing. Despite concurrent policy shifts towards universal healthcare, socialist policies, and Intercultural/pro-indigenous rhetoric in other Latin American countries at the time, Ecuador is unique in its breadth of institutional reforms and the direct involvement of indigenous movements (at least initially) in shaping policy. Intercultural Health in Ecuador is a clear example of resistance “from below” impacting policy and biopolitical agendas “from above” to legitimize previously marginalized groups and ways of life. While the impact of this biopolitical inclusion was not always successful nor beneficial, I argue it is an important example of a purposeful and explicit attempt at an affirmative biopolitics of the state in the real-world. By examining the complex frictions and diverse perspectives across the implementation of biopower, I am to provide a more nuanced analysis to biopolitical theories rooted in political and historical philosophy.

Recognized as one of the strongest indigenous rights movements in Latin America, a series of indigenous uprisings in Ecuador from the 1990s and early 2000s helped remove two presidents from office (Becker 2011). As part of larger demands for self-determination in a plurinational state, the indigenous movement proposed Intercultural Health as a way to legitimize traditional medicines and increase indigenous autonomy in healthcare (CONAIE 2010, Becker 2011). Building upon these demands, the election of economist Rafael Correa as president in 2007 re-oriented national policy towards neo-socialism, politics of recognition, and participatory citizenship under the national Development Plan for *Buen Vivir* [Good Living]. Unlike similar rhetoric in other Latin American countries, these reforms have been extensively incorporated into state policies that have radically transformed the accessibility, accountability, and quality of public healthcare services. Both the new politics of *Buen Vivir* and Intercultural Health have been lauded internationally as models of more inclusive and humanist forms of governance (Acosta 2009, Villalba 2013, Radcliffe 2018).

Based on twelve months of research at a clinic combining Ministry of Public Health (MSP) physicians and indigenous traditional midwives in the Ecuadorian Amazon, I examine how the attempt to include indigenous lifeways in state biopolitics is understood, implemented and experienced through the design and implementation of Intercultural Health policies. In Chapter 2 I propose four necessary components for an affirmative biopolitics, which then frames a comparative analysis of how *Buen Vivir* and Interculturality are operationalized at the levels of national policy design, biomedical service implementation, and local traditional medicine. Based on participant observation and interviews with policy makers, activists, administrators, biomedical providers, and traditional medicine practitioners, I argue that biopolitical agendas and the policies that shape them are negotiated in complex ways both within and outside of state institutions.

Although they do not always achieve the desired effect, policy makers, activists, biomedical providers, and traditional practitioners in Ecuador are attempting to reshape which forms of life and strategies of well-being are considered legitimate by the state. As they do so, they directly question the role of biomedicine in achieving a good life and confront the ways traditional medicines are enumerated and valued by state institutions. Despite radical calls from indigenous rights activists to decolonizing healthcare, the scope and design of Intercultural Health policies have been shifted by international activism and policy networks, and limited by existing inequalities of power. Thus, I argue that any attempt to operationalize an affirmative biopolitics is an iterative process that inevitably turns a utopic vision into a tangled chimera that can achieve some (but not all) reforms and creates new potential sources of control.

1.1 Interculturality, *Buen Vivir*, and the Citizens' Revolution

The political shifts that occurred in Ecuador in the 1990s and early 2000s have been referred to as an "ontological turn" in the state's methods of development and construction of its imagined identity (Escobar 2010, Alonso González and Vázquez 2015). Specifically, they sought a plurinational state that both protected the ways of life of indigenous and other minority groups while providing increased legal self-determination. Rather than emphasize the capitalist goal of accumulating wealth, the reforms pushed for a "good way of life" or *Buen Vivir* for all Ecuadorians inspired by Kichwa values of *Sumak Kawsay* [living well]. This 'new Ecuador' would be characterized by Interculturality, often defined as open, equal, and mutual dialogue between distinct groups to create a shared benefit for all (Fernandez-Juárez 2010). Starting as demands from the indigenous movement, the concepts of plurinationality, Interculturality, and *Sumak Kawsay* were then employed by the reformist president, Rafael Correa, and enshrined in the 2008 constitution. However, these were not cohesive discourses that moved up the political ranks, so to speak. Instead, they were adopted and adapted by diverse networks advocating for change, what Hardt and Negri refer to as the "multitudes" (2005). Through several processes of translation and redefinition, these concepts were transformed into an affirmative biopolitics, albeit with significant conflict and debate.

The origins of the terms *Interculturalidad* [Interculturality] and *Sumak Kawsay* are unclear. Significant debates surround whether they were coined **by** indigenous groups or **about** them by social scientists and international NGOs (Lopez 2009, Bretón, Cortez et al. 2014, Alonso González and Vázquez 2015). Regardless, they are understood in their most essential forms as glosses for the lived experiences and ontologies of indigenous peoples. For example the Whitten's, preeminent scholars of Amazonian Kichwa communities, has posited that Interculturality is a representation of the importance placed in most indigenous groups on interactions with cultural outsiders, both human and non-human, in order to strengthen one's own life and community (see also Cachiguango 2010, Whitten and Whitten 2015). It is also seen as a consequence of the ways indigenous peoples have been forced to confront other cultures through processes of labor exploitation, missionization, and development programs (Uzendoski and Whitten 2014). This relationship with alterity is considered an essential component of living well (Cachiguango 2010, Uzendoski and Whitten 2014). The idea of *Sumak Kawsay* [Living Well,], then, is said to represent indigenous values of "living in plenitude, knowing how to live in harmony with the cycles of Mother Earth, of the cosmos, of life and of history, and in balance with every form of existence in a state of permanent respect" (Mamani 2010).

The concept of Interculturality likely grew out of the convergence of several "intercultural" discourses that heavily influenced bilingual education in the 1970s and 80s (Lopez 2009, Cortes Mateos 2011, Cuvi and Poats 2011). At the time, bilingual education was often run by local indigenous groups in partnership with religious and development organizations, but formed part of larger state projects to assimilate children towards hegemonic Spanish-speaking culture (Lopez 2009). Eventually, the networks supporting bilingual education projects advocated for meaningful incorporation of indigenous customs and ontologies in the curriculum. One such discourse came from social scientists working on education projects in indigenous communities. This includes a 1974 theory of "inculturation" from Venezuelan linguists Mosonyi and González (Lopez 2009). Another stems from Liberation Theology and Inculturation Theology movements in the Catholic Church that supported such projects (Yashar 2005, Martínez Novo 2010). In addition, European NGOs funding bilingual schools were influenced by growing pressures for cross-cultural education programs for migrants in their home countries (Cortes Mateos 2011).

By the end of the 1980s, these various discourses coalesced into the framework of *Educación Intercultural Bilingüe* [Intercultural Bilingual Education, or EIB] designed to teach indigenous language, culture and ontology. With the financial and logistical support of foreign NGOs and the Catholic Church, EIB and Interculturality quickly spread throughout the Andes and became platforms of political activism (Cortes Mateos 2011). In 1986, this led in part to the formation of the Confederation of Indigenous Nationalities of Ecuador (CONAIE), the first indigenous organization to formally unite indigenous (and later Afro-Ecuadorian) federations from the Coast, Sierra, and Amazon. It was a political achievement, as highland groups were largely concerned with land rights and neoliberal policies, while Amazonian groups generally challenged extractive industries and environmental contamination (Becker 2011). CONAIE was able to create a shared platform demanding land rights, cultural recognition, economic development funding, EIB, and recognition of traditional medicines (Zamosc 2007, CONAIE 2010, Becker 2011).

The crash of oil prices and resulting neoliberal austerity measures in the early 1990s increased political discontent throughout the country. CONAIE was able to transcend indigenous politics and partner with many smaller economic, environmental, and religious organizations to organize a series of nation-wide political uprisings in 1990, 1992, 1994, 1996, 2000, 2002, and 2005 (Zamosc 2007, Becker 2011). The protests significantly disrupted state functions and resulted in removing President Bucaram and President Mahoud from power in 1997 and 2000, respectively (Becker 2011). During this period, Interculturality expanded to form a pillar of indigenous demands for a plurinational state:

> The principle of Interculturality respects the diversity of indigenous towns and nationalities as well as other Ecuadorian social sectors. However, it also demands the unity of these groups in economic, social, cultural, and political issues in the interests of transforming current structures into a new plurinational State. It is a framework of equal rights, mutual respect, peace, and harmony between nations. (CONAIE 2010, originally published 1997)

For the indigenous movement, Interculturality was the method for establishing structures of participatory democracy and self-determination over their ways of life, resources, economies, and institutions (Walsh 2002, CONAIE 2010).

It is important to note, however, that the goal of CONAIE was not to destroy or even supplant what it saw as an exclusionary or repressive state. Instead, it aimed to work both within and outside of institutions to restructure state power and governance to guarantee autonomy amongst diverse nations and peoples (Becker 2011). For this reason, CONAIE created its own political party, Pachakutik, and pushed for democratic reforms that would allow them to enact internal changes on their own terms. At the same time, activism on the ground and pressure from international agencies incentivized institutions to adapt. In this way, the Interculturality of the indigenous movement should not be understood as a form of resistance, but as a process of continual transformation.

Much like Interculturality, the paradigm of *Sumak Kawsay* emerged through networks of academics, indigenous organizations, and NGOs. There remains significant debate as to whether it began as an emic reference of indigenous peoples for their own ontologies (Cachiguango 2010, Simbaña 2012, Cubillo-Guevara and Hidalgo-Capitán 2015) or as an etic label for indigenous constructions of the good life by social scientists and later NGOs and activist groups working with indigenous communities (Hidalgo-Capitán and Cubillo-Guevara 2014, Alonso González and Vázquez 2015). Regardless, *Sumak Kawsay* is understood as being rooted in indigenous (particularly Kichwa) values that often contradict those of the hegemonic mestizo and capitalist state (Radcliffe 2018). Just as with Interculturality, its use as a political term began in the uprisings and quickly spread through international networks to become a rallying cry for indigenous rights, decolonization, and alternatives to neoliberal development models (Bretón, Cortez et al. 2014, Vanhulst 2015, Radcliffe 2018).

The Ecuadorian indigenous movement dramatically impacted national politics by expanding from activism based on ethnicity to an activism of the multitude based on critiques of the state. However, this meant the paradigms of Interculturality and *Sumak Kawsay* were continually translated and reinterpreted by the conglomeration of diverse groups who sought change (Cubillo-Guevara, Hidalgo-Capitán et al. 2013, Cuestas-Caza 2018, Altman 2020). This is particularly visible in the case of *Sumak Kawsay*, which was translated both literally and figuratively to Spanish as *Buen Vivir* [good living], and other indigenous languages such as Aymara (*Sumaq Qumaña)* and Mapuche (*Küme Mongen*) (Vanhulst and Beling 2014). These translations and co-optations of *Sumak Kawsay* and Interculturality ultimately created a multiplicity of meanings and applications that alienated the terms to varying degrees from the indigenous ontologies and activists that inspired them (Maldonado Ruíz 2010, Simbaña 2012, Viola Recasens 2014, Vanhulst 2015, Cuestas-Caza 2018, Altman 2020).

Interculturality has been utilized to selectively promote community-based approaches, culturally adapted services, and events/initiatives that are markedly indigenous (Menéndez 2006, Ramirez Hita 2009, Viaña 2010, Flores Martos 2011). *Sumak Kawsay* and *Buen Vivir* on the other hand, have been proposed as a post-colonial, anti-neoliberal development framework that prioritizes human and environmental wellbeing over economic productivity (Acosta 2009, Maldonado Ruíz 2010, Monni and Pallottino 2015, Radcliffe 2018). Depending on who is using it, *Buen Vivir* has been used to promote anti-extractivism, sustainable development, and increased social investment (Cubillo-Guevara, Hidalgo-Capitán et al. 2013, Vanhulst and Beling 2014, Alonso González and Vázquez 2015, Altman 2020).

The multiplicities of meanings associated with *Buen Vivir* and *Sumak Kawsay* only increased with their adoption by Rafael Correa and his party, Alianza PAIS. Leading up to his election in 2006, Correa tried to foster a partnership between Alianza-PAIS and Pachakutik, as well as other indigenous organizations. He wore traditional embroidered shirts and gave speeches in Kichwa, broadening the support he had already garnered as a socially conscious finance minister under President Alfredo Palacio (2005-2007). Correa presented himself as a revolutionary force against the unstable governance and neoliberal policies of the previous 10 years. Central to his platform was what he called “socialism for the 21st century,” where national wealth would be redistributed through social investments in education, healthcare, infrastructure, and other services. In particular, he called for a "Citizens’ Revolution" to dramatically restructure the state, comprised of five main components:

> 1) **A Constitutional and Democratic Revolution** to establish citizen participation at all levels of governance; 2) **An Ethical Revolution** to establish a transparent and accountable government; 3) **An Economic, Productive, and Agrarian Revolution** to undo neoliberal and colonial exclusionary economic policies and increase community control over extractive industries; 4) **A Social revolution** where the state guarantees fundamental rights of education and health; and 5) **A Revolution of Sovereignty and Integration** to reinforce relationships with regional and international institutions/governments. (SENPLADES, 2009).

The multiplicity of meanings of both Interculturality and *Sumak Kawsay* became central components of Correa's rhetoric of national transformation. Through Correa's government, Interculturality and *Sumak Kawsay/Buen Vivir* became codified law, through their repeated inclusion in the 2008 Constitution and as the primary epistemological orientation of the national development plan:

> Our concept of *Buen Vivir* compels us to rebuild the public sphere in order to recognize, understand and value ourselves as diverse but equal individuals, and in order to advance reciprocity and mutual recognition, enable self-advancement, and build a shared social future. (SENPLADES, 2009, p. 6)

For Alianza PAIS, *Buen Vivir* was a radical goal of transformation that would create a more inclusive and participatory society. Interculturality was framed as a mechanism to create this change, but the primary mechanism was the Citizens' Revolution that would establish the institutional structures and social supports necessary for participatory citizenship of all Ecuadorians (SENPLADES, 2009).

1.1.1 *Buen Vivir* and Interculturality as National Policy

In both governmental and alternative development discourses, *Buen Vivir* and *Sumak Kawsay* are often considered interchangeable translations of the same concept. However, many researchers and activists note they are neither proper linguistic translations nor epistemological equivalents (Simbaña 2012, Hidalgo-Capitán and Cubillo-Guevara 2014, Cuestas-Caza 2018). Cuestas-Caza divides discourses of *Sumak Kawsay/Buen Vivir* into three categories (2018). Indigenous-culturalist constructions exclusively use *Sumak Kawsay* to refer to a "pure" representation of indigenous ontologies and activism, even if it may have been co-opted or superimposed by outsiders (Cubillo-Guevara and Hidalgo-Capitán 2015, Villalba-Eguiluz and Etxano 2017, Cuestas-Caza 2018). Post-developmentalist paradigms, however, often interchange the terms as they combine aspects of indigenous ontology with other post-modern and post-developmental theories (Thomson 2011, Cubillo-Guevara, Hidalgo-Capitán et al. 2013, Cuestas-Caza 2018, Altman 2020). Finally, socialist-statist constructions utilize both terms but prioritize *Buen Vivir*, as they emphasize neo-socialism and "neo-extractivism" (Villalba-Eguiluz and Etxano 2017, Cuestas-Caza 2018, Altman 2020).

These multiple usages of *Sumak Kawsay/Buen Vivir* often conflict with one another and obscure the indigenous values and activism originally attached to them, particularly post-developmentalist and socialist-statist discourses (Uzendoski and Whitten 2014, Viola Recasens 2014, Cuestas-Caza 2018). In addition, they often exploit indigeneity to romanticize environmentalism and other progressive causes in what has been critiqued as *pachamamismo* (Viola Recasens 2014, Alonso González and Vázquez 2015).[2] The "good life" of indigenous-culturalist *Sumak Kawsay* is often differentiated from the socialist-statist *Buen Vivir* in two important ways. *Buen Vivir* explicitly relies on "neo-extractivism," where centralized wealth is accumulated through extractive industries (especially petroleum) in order to fund the expansion of governmental infrastructure and social services required to achieve its definition of "the good life" (Villalba-Eguiluz and Etxano 2017, Martínez Novo and Shlossberg 2018). In contrast, *Sumak Kawsay* emphasizes subsistence and communal wealth built through reciprocal relations (Simbaña 2012, Whitten and Whitten 2015, Altman 2020). In addition, constructions of "pure" *Sumak Kawsay* include radical plurinationality, while *Buen Vivir* emphasizes citizen participation within state institutions (Cubillo-Guevara, Hidalgo-Capitán et al. 2013).

Given these distinctions, many indigenous communities in Ecuador now view both *Sumak Kawsay* and *Buen Vivir* as either fully co-opted or foreign concepts and avoid using them for their own political purposes (Simbaña 2012, Uzendoski and Whitten 2014, Bridges 2017). This has led to counter-discourses, including that of *Kawsak Sacha* [Living Forest] advocated by the politically active Amazonian Kichwa community of Sarayaku (Coba and Bayón 2020). In Chapter 5, I will address how Napo Runa community members juxtapose socialist-statist forms of *Sumak Kawsay/Buen Vivir* with local constructions of living well, *Alli Kawsana.*

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[2] From the Kichwa term *pachamama* [Earth Mother], roughly translated as "Mother-Earthism"

Despite the multiplicity of their forms, the adoption of Interculturality and *Buen Vivir* in national policies has led to sweeping government reforms. This includes an unprecedented increase in public expenditures on health and education. For healthcare alone, spending rose from 4% of the GDP in 2006 to 13% of the GDP in 2011 (Jiménez-Barbosa, Granda-Kuffo et al. 2017). The government also mandated prior-informed consent of indigenous communities before resource extraction and created the *Consejo de Participación Ciudadana y Control Social* [Council on Citizen Participation and Social Control] designed to raise awareness of citizens' rights and help them launch complaints against government institutions. Furthermore, all government institutions at all levels are required to perform an annual *rendición de cuentas* [public performance review forum] to ensure accountability, transparency, and citizen participation.

As the Correa administration stayed in power through 2017, a growing body of research highlights the conflicts between government discourse and praxis. Several presidential decrees have significantly tightened governmental controls over civil society and have been used to penalize groups viewed as political dissidents (Martínez Novo and Shlossberg 2018).[3] Indigenous organizations, particularly CONAIE, were specifically targeted as they increasingly critiqued the Correa Administration for ignoring and undermining indigenous concerns (Martínez Novo and Shlossberg 2018). Additionally, the government has reversed many policies of environmental protection and prior-informed consent, most notably with the termination of the Yasuni ITT initiative (Villalba-Eguiluz and Etxano 2017). For these reasons, governmental discourses of Interculturality and *Buen Vivir* have been widely critiqued as political posturing, co-optation, and ventriloquism that gave the Correa administration a widespread political appeal but obfuscated

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[3] These include Executive Decree 16, which gives the government full authority to close NGOs at any time; and Decree 813 that removed supposedly removed "corrupt, lazy, and delinquent" public service employees, but was largely criticized as an attempt to eliminate political dissidents.

policies seeking to expand governmentality, extractive industry, and re-subjectification of indigenous peoples as passive recipients of government policies (Uzendoski and Whitten 2014, Villalba-Eguiluz and Etxano 2017, Martínez Novo and Shlossberg 2018, Altman 2020).

Therefore, it is important to understand that *Buen Vivir/Sumak Kawsay* and Interculturality are, historically and politically, complex terms. The criticisms of the Correa administration's uneven and subversive application of these discourses should not ignored. However, the epistemological and political conflicts should not negate the impact of Interculturality and *Sumak Kawsay/Buen Vivir* in catalyzing an important shift wherein activists and the state alike attempted to incorporate and support multiple ways of life (Walsh 2010, Alonso González and Vázquez 2015, Cuestas-Caza 2018, Radcliffe 2018). As Alonso González and Vázquez note, "asking whether *Buen Vivir* is 'true' or 'false' is unproductive, because it always functions in complex assemblages where desire, interest, knowledge, and power converge in the construction of something new" (2015). As such, in my analysis I will demonstrate how government institutions and indigenous communities negotiate various discourses and modes of implementation of Interculturality and the meaning of the "good life."

Most importantly, I argue that these political frictions should not only be understood as discourse and praxis, but as an attempt at an affirmative biopolitics of the state that changes how a Good Life is evaluated and valued. This is most clearly seen in the National Plan for *Buen Vivir*:

> Development as modernization and economic growth tends to be measured through the variations of the Gross Domestic Product (GDP.) …In contrast, **"human development"** defends the idea of development based on human beings, and not merely on markets or production. **What must be measured, therefore, is not GDP but the living standards of people through indicators related to the satisfaction of their human needs**. (SENPLADES 2009) [mphasis mine].

This biopolitical shift was cemented with the updated plan for 2013-2017, which set targets for key educational, poverty, democratic, environmental and health indicators. Objective 3, "Improving Quality of Life," included reducing the maternal mortality rate from 70.4% to 50%, and the infant mortality rate from 10.1% to 6%, and increasing access to water service from 74.5% to 95% of the population. Objective 5, "Constructing Spaces of Encounter and Strengthening Interculturality," includes goals such as increasing the percentage of generational transmission of native languages, and increasing the percentage of the population who participate in cultural and sporting events (SENPLADES 2013).

In the following chapters, I examine how changes in national health policy and administration reflect an attempt at affirmative biopolitics. Specifically, I trace the complex negotiations between biopolitical measures and diverse conceptions of Interculturality and *Buen Vivir* in the design, implementation, and evaluation of Intercultural Health policies. In Chapter 2, I will discuss the theoretical underpinnings of affirmative biopolitics and outline Buen Vivir as a primary example. In Chapter Three, I will outline the history and diversity of discourses in Intercultural Health policies. In Chapters Three, Four, and Five, I will discuss the challenges of applying affirmative biopolitics in real-world policies and practices in the context of Intercultural Health. Ultimately, I describe how the translation of utopic political discourses into actionable policy is laden with conflicting values of culture, labor, knowledge, and well-being.

1.2 Research Setting

Ecuador claims to be one of the most biodiverse countries in the world in terms of ecosystems and cultural groups. Its three ecological zones have retained distinct regional differences in food, language, and ethnic groups. The coastal region along the Pacific Ocean has the highest proportion of Afro-Ecuadorians, the recently recognized Montubios, and is also home to the Awa, Chachi and Tsáchila indigenous nationalities. In the Sierra region the Andes mountains create a natural barrier between the western coast and the rainforest to the east. Once part of the Inca empire, indigenous peoples of this region are Sierra Kichwa speakers who are officially subdivided into 14 distinct pueblos [communities/peoples]. The Sierra is home to the country's capital city of Quito and to Otavalo, the epicenter of wealthy indigenous elites (Sierra Kichwa) with significant political influence.

The research for this project was primarily situated in Napo Province, part of the Oriente or Lowland region. This region forms part of the Amazon basin, and the easternmost portions contain large segments of unpopulated rainforest. The largest indigenous groups in the Oriente are the Shuar, Amazonian Kichwa, Achuar and Huaorani. In total, the Ecuadorian government recognizes 14 nationalities and 18 Kichwa Pueblos. At the national level, 71.9% of Ecuadorians identify as mestizo, 7.4% Montubio, 7.2% Afro-Ecuadorian, 7.0% indigenous, and 6.7% white (INEC 2010). This number is disputed however, with some (especially CONAIE) claiming that almost 25% of the population is indigenous (Vanhulst 2015).

1.2.1 National Healthcare System

The Ecuadorian healthcare system is broadly divided into three sectors. The Ministry of Public Health (MSP) operates multi-level care from small rural health posts to large specialty hospitals in urban centers. The Social Security Institute (IESS) provides a parallel system for workers, funded through payroll tax and individual insurance premiums. Finally, the private system includes clinics and hospitals, many with religious affiliations. This creates a tiered system, whereby the MSP largely services poor and rural populations and the IESS and private systems treat the middle and upper classes. However, the MSP system operates the largest number of health institutions and provides care for the majority of the population, due in part to the large proportion of people reliant on the informal economy (Lucio, Villacrés et al. 2011).

Since the 1970s, the population of Ecuador has undergone a delayed epidemiologic transition, with high incidence of both infectious diseases often closely tied with poverty, and non-communicable or “lifestyle” diseases such as diabetes (Marinho, Soliz et al. 2013). As Correa himself noted, 80% of the health problems of Ecuadorians could be resolved in primary care (De Paepe, Tapia et al. 2012). As in many other countries, there is a significant gap in health outcomes for indigenous populations compared to the rest of the country, in part because they are much more likely to live in rural areas and in conditions of poverty. These differences became clear with the 2004 national health survey, which evidenced many of the inequalities highlighted by the indigenous uprisings. In 2004, 84% of indigenous families lived in poverty (Winkler 2004), and only 5% owned a vehicle (CEPAR 2004). Likewise, 69% of indigenous women gave birth at home compared to 18% of mestizas, and only 17% completed the 5 prenatal exams recommended by the MSP (CEPAR 2004). Despite reforms, health disparities remain. In 2012, for example, rates of both stunting and overweight in children under 5 years old remained twice as high for indigenous peoples than any other ethnic group (MSP and INEC 2014).

Before healthcare reforms, financial costs were one of the primary considerations of where residents decided to access healthcare (CEPAR 2004). In addition, distance and lack of transportation were and continue to be significant barriers to health care for rural and indigenous populations (MSP and INEC 2014). However, rates of institutional service utilization by indigenous residents were often even lower than those in rural areas or the lowest economic quintile. While this is due in part to cultural preference, several studies in Ecuador have also documented significant maltreatment of indigenous patients ranging from verbal abuse to grave medical malpractice (Koblinsky, Matthews et al. , MSP 2009, Hermida, Fuentes et al. 2010, Brandao, Cañadas et al. 2018, Meijer, Brandao et al. 2019). For this reason, reforms of the national healthcare system have emphasized Interculturality and human rights (discussed in depth in Chapter 3). Intercultural Health programs are currently the MSP's primary strategy for addressing patient preference and maltreatment in indigenous regions (Mignone, Bartlett et al. 2007, SENPLADES 2009, Hermida, Fuentes et al. 2010).

To achieve the Plan for *Buen Vivir* and the Millennium Development Goals (MDGs), the Correa administration prioritized sweeping reforms of the national healthcare system to provide truly free universal healthcare to all, referred to as the TSSE or *Transformación Sectorial de Salud del Ecuador*. As with the Citizens' Revolution generally, the explicit goal was to foster a politically active citizenry through free access to quality health services, structures of participatory democracy, and *concientización* [awareness raising] of health issues and health related rights. For the MSP specifically, the goals of the transformation were to improve the legitimacy of the MSP as a respectable/reliable healthcare provider, expand service coverage and access, increase the power of citizens in managing/overseeing MSP services, and adapt services to the diverse needs of **all** Ecuadorians (particularly ethnic minorities, low-income, and rural residents) (MSP 2009).

For this reason, the reorganization created new administrative bureaus governing all levels of the MSP. Part of the "ethics revolution," new directorates of health service quality, and standardization of care and health professionals were meant to improve service standards, minimize corruption, and increase transparency with the public. In addition, the reorganization created the *Proceso de Promoción de la Salud e Igualdad* [Bureau of Health Promotion and Equality], tasked with incorporating the "social" and "democratic" revolutions through directorates of health promotion, human rights, Intercultural Health, and social participation. The objectives of this bureau were to increase health literacy, incorporate diverse health beliefs/practices, and actively involve citizens in all levels of MSP administration and oversight.

In addition, the structure of healthcare networks was completely reorganized to dramatically expand access to primary and preventative health services. The TSSE included implementation of a mutual referral/reimbursement network between private providers, the IESS, and the MSP; allowing citizens to receive care in any health establishment from any health sector. However, this was not fully functional at the time of research. At the institutional level, the MSP care network was reorganized into nine health zones (comprised of two to three provinces) and sixteen subordinate health districts. This process aimed to share management and planning responsibilities among the central MSP office, health zones, and district offices (*desconcentración)*; while giving zonal and district offices more authority to tailor the provision of health services to local needs (*decentralización)*.

Finally, the structure of community and hospital services were rearranged to provide broader access to essential services and decongest hospitals, which in turn would allow for more specialized services in smaller urban centers. In the old system, community care was provided in small rural *puestos* [health posts] with one or two providers, parish level *subcentros* [small health centers] with family/general medicine and dentistry, and urban/county *centros* [health centers] with the added specialties of obstetrics/gynecology and basic laboratory services. The new system, outlined in the MAIS-FICI, replaces the *subcentros* and *centros* with Type A and Type B health centers, and establishes a new intermediary level of care between the old *centros* and general hospitals, Health Center Type C (see Table 1). Most importantly, the MAIS-FICI introduced a basic community care team, the *Equipos de Atención Integral de Salud* (EAIS), comprised of one family physician, one nurse, and one TAPS (community health worker) for every 2,000-4,000 inhabitants. These EAIS teams staff the health posts and centers, along with any respective specialties and technicians. The EAIS forms the axis of the shift towards preventative and primary care, with each team required to provide both educational outreach and medical care in clinical and community settings. This means each health center holds consultations in clinic, medical brigades in service communities, and target outreach at schools and public events.

Table 1. MSP Health Services According to Level of Care

Level	Old Type	New Type	Services/Provider	Population
Primary	n/a	EAIS	Family physician, nurse, TAPS	4000 urban 2000 rural
	Puesto	same	Nurse or TAPS, itinerant EAIS	2000 (rural only)
	Subcentro	n/a	EAIS, dentistry, basic pharmacy	
	Centro de Salud	Health Center A	EAIS, dentistry, sample collection, pharmacy, obstetrics/birth room	5-10,000
		Health Center B	EAIS, dentistry, sample collection, pharmacy, urgent care	10-50,000
	n/a	Health Center C	EAIS, dentistry, short-term maternity, psychology, dietitian, IV, ER, laboratory, basic imaging, rehabilitation and specialty therapy services	25-50,000
Secondary	Basic Hospital	Same	Internal Medicine, dentistry, ER, Long-term maternity, pediatrics, general surgery, radiology, institutional pharmacy & laboratory	50,000+
	General Hospital	Same	Same as above plus neonatology, pathology, intensive therapy, and additional specialties based on epidemiological need (ex. Cardiology, burn unit, dialysis, etc.)	75,000+
Tertiary	Specialty Centers	Same	Diagnosis & treatment in one or more specialty (ex. mental health, dermatology)	
	Specialized Hospitals	Same	Complex care hospital with multiple specialties, high-tech equipment	

Ecuador does not recognize any level of professional biomedical midwifery such as nurse midwives. Institutional births are attended by doctors, primarily obstetricians or gynecologists. A small number of foreign-trained biomedical midwives offer home birth services, particularly in urban centers, but they are not formally affiliated with any healthcare institutions. Legally, they operate as informal practitioners, the same standing as traditional midwives or shamans. Everyday references to "midwives" are broadly understood as meaning both traditional and lay midwives. For this reason, I also use "midwives" to refer specifically to this group of informal practitioners regardless of any certifications or international training they may have. This distinction is important, as Intercultural Health initiatives in other countries are principally implemented via professional biomedical midwives (see Vega 2017, Guerra-Reyes 2019).

The overhaul of the public healthcare system required a dramatic increase in public spending to expand physical infrastructure, acquire advanced medical equipment, and hire health personnel. From 2006 to 2016 health expenditures increased by $16 billion, clearly demonstrating a shift in political and economic focus towards guaranteeing universal healthcare. From 2012 through 2015 the MSP built ten new hospitals, extensively remodeled eight hospitals, and constructed 51 new health centers (Vance 2016). In only two years (2012-2014) the MSP hired 12,000 additional health personnel by increasing the capacity of higher education programs, attracting the return of emigres, and by directly contracting physicians from the Cuban government.[4] By 2016 30 hospitals had become internationally accredited (Vance 2016).

Nevertheless, progress was slow and uneven, due in large part to the extensiveness of the changes to the MSP. The increase of services offered at the primary care level meant most existing facilities were inadequate, so the new categories of Health Centers were only implemented via

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[4] In 2013 the Correa government contracted 1,000 Cuban physicians to specialize in integrated family medicine in rural and community health posts throughout the country. This was in part to address the lack of family practitioners in the expanding national system, with only 188 such specialists listed in 2011 Sosa, D. (2013). Médicos cubanos en Ecuador ganarían hasta $2.600. Marti Noticias. Online..

new construction. By the time of this research in 2015, most health districts retained a majority of old primary care services with only a handful of Type A, B, and C Health Centers. In addition, the construction and remodeling of hospitals was often significantly delayed and over budget. Despite purchasing more advanced medical equipment to expand diagnostic and treatment capabilities, many of the designated hospitals and health centers lacked the trained professionals to operate them for extended periods of time (Torres and López-Cevallos 2018). Finally, the increase in public spending was funded through historically high oil prices, but their precipitous drop between 2014 and 2015 began to severely impact state funding. As I conducted research, the phrase "economic crisis" was frequently used in both casual conversation and official discussions as an all-encompassing explanation for challenges faced by institutions and everyday Ecuadorians alike.

By 2015, Ecuador had made significant strides towards achieving the MDGs and *Buen Vivir* objectives in health. From 2006 to 2015 the child mortality rate dropped from 27.7 to 15.1 deaths per 1000 births (World Bank 2021). During the same period, life expectancy increased by three years (World Bank 2021). The universalization of healthcare also had a notable impact on the number of care encounters within the MSP, increasing from 14 million in 2006 to 38 million in 2013 (Chang Campos 2017). Similarly, institutional births[5] increased from 78.5% in 2004 to 92.3% in 2012 (MSP and INEC 2014). Rates of institutional prenatal and birth care among indigenous women also increased dramatically during the same time period, with 47.4% of indigenous women completing five prenatal checkups and only 31.6% giving birth at home (demonstrating a change of approximately 30 percentage points each since 2004) (MSP and INEC 2014). Nevertheless, these indicators are still remarkably different from the national averages of

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[5] Births that occurred at any formal health center: public or private, clinic or hospital.

79.5% of all women completing five or more checkups and only 6.5% of births at home (MSP and INEC 2014).

1.2.2 Napo Province

The primary settings for this dissertation research are the cities of Archidona and Tena, the largest cities of Napo province. Nestled between the highland province of Pichincha and the Amazon province of Orellana, Napo occupies an important ecological transition zone between the Andes mountains and the Amazon Basin (see Figure 1). While most Ecuadorians romanticize Napo as untamed jungle, it is actually fairly mountainous and urban compared to other regions of the Oriente. In both past and present, the province has been an important commercial center for trading/transporting raw resources from the rainforest and products from Quito. This has made Napo something of a cultural transition zone as well, where culturally Amazonian indigenous peoples predominantly speak Kichwa, a language traditionally associated with the Highlands of the Andes Mountains (Mannheim 2011). Amazonian Kichwa and Sierra Kichwa generally view

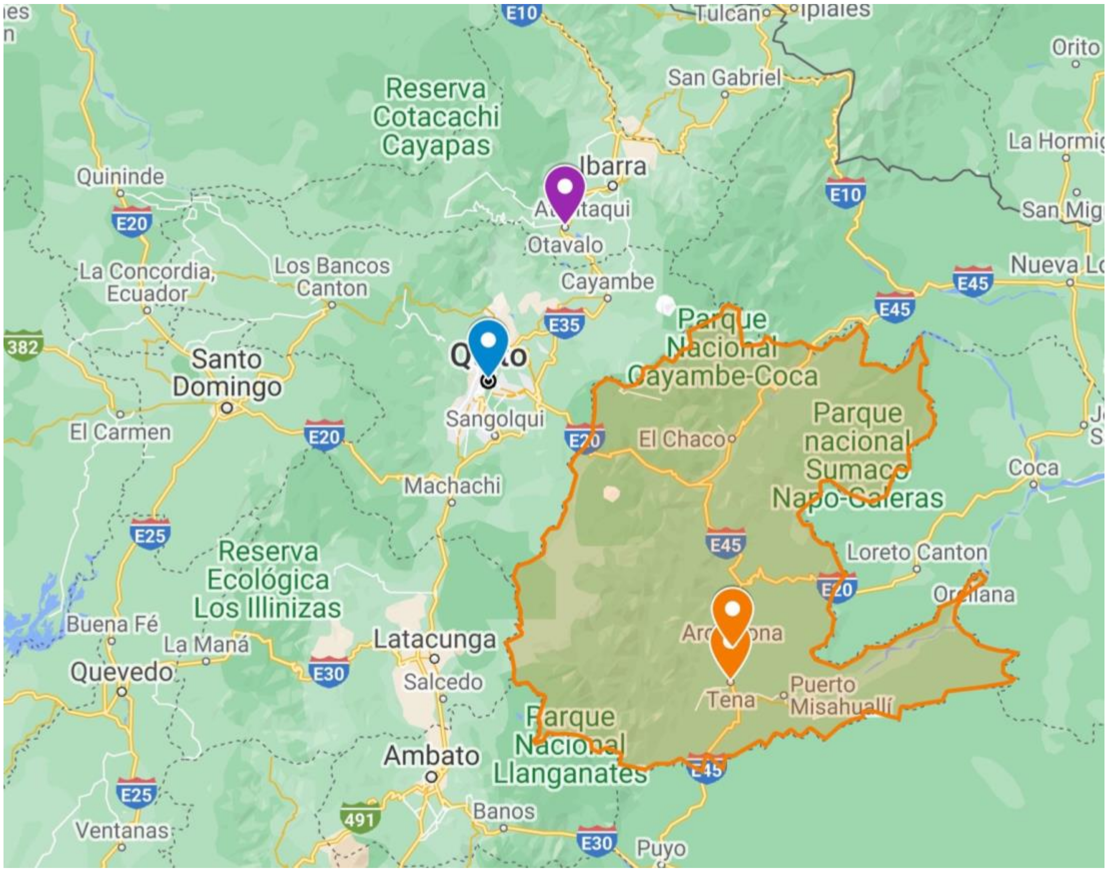

Figure 1. Map of Napo Province
(Google Maps 09/15/2021)

themselves as separate nationalities, a division also recognized (albeit inconsistently) by the Ecuadorian government. Amazonian and Sierra Kichwa (also referred to as lowland and highland Kichwa) are mutually intelligible but retain significant linguistic differences and are widely viewed to be separate dialects. Furthermore, these groups maintain highly distinct traditions in clothing, foods, medical beliefs/practices, and ontologies.

The history of the Amazonian Kichwa dialect is heavily debated by academics and local residents alike.[6] However, general consensus is that it stems from a long and robust interaction between highland and lowland indigenous populations, with additional cultural impositions from

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[6] While conducting fieldwork I attended a public forum hosted as part of the Jumandy Festival where the local history of the Napo Kichwa (particularly whether they are the descendants of the Quijos) was hotly contested amongst mostly indigenous residents.

the Inca and then the Spanish. A vast trade network connected the different ecological zones, and likely introduced Kichwa as a lingua franca with the expansion of the Inca empire into the Ecuadorian Andes, and even possibly into parts of Napo (Oberem 1980, Uzendoski 2005, Muysken 2011). After the Spanish conquest, Catholic missions purposefully spread Kichwa as a lingua franca amongst the diverse indigenous groups they gathered to create large settlements (Oberem 1980). Through the first half of the 20th century, contact between Amazonian tribes and both lowland and highland Kichwa speakers continued through forced labor migrations and lowland Kichwa speakers fleeing in attempts to escape them (Oberem 1980).

Despite a series of cultural impositions and destabilizing forces, a cohesive identity of Amazonian Kichwa speakers was formed. Both culturally and linguistically, the Amazonian Kichwa are comprised of the Napo Runa[7] in the north and Pastaza Runa in the south. Pastaza Runa tend to live in much more remote communities and have some unique ceramic and folklore traditions. Their dialect is more heavily influenced by Zaparo and Jivaroan languages (Whitten and Whitten 2008). As my research was conducted in Napo, I will mostly address the perspectives of Napo Runa.

Due in part to this complex history, the Amazonian Kichwa are often erased within the imagined indigenous community of the state. For most Ecuadorians, including many non-indigenous in the Amazon, Kichwa is emblematic of highland indigenous groups and customs. Whereas the indigenous peoples of the Amazon are thought of as the Huaorani or Shuar who are

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[7] As in many other indigenous groups, speakers of Amazonian Kichwa refer to themselves by the term *runa* [person/human being] that also indicates cultural affinity. Thus, *runa* is used to designate what is or is not markedly Kichwa, such as *runa shimi* [Kichwa language], *runa mikuna* [Kichwa good/gastronomy], and *runa kawsay* [Kichwa way of life]. It is contrasted with the terms *mishu* [mestizos], *gringu* [whites/foreigners]. and *auka* [indigenous others such as Huaorani and Shuar].

viewed as more "savage" (but are much less prevalent than lowland Kichwa). Government policies and initiatives often contribute to the erasure of Amazonian Kichwa identity and language through increased emphasis on both Spanish and *Kichwa Unificado* (Uzendoski 2009, Grzech 2017). Adopted by the state as the second official language in 2008, *Kichwa Unificado* is a standardized form largely based on highland dialects. It is the mandatory form of Kichwa utilized in Intercultural Bilingual Education, public media, and bilingual signage in MSP health centers. The increased funding of EIB and cultural activities in the Correa administration have contributed to making *Kichwa Unificado* a prestige language, which in turn is seen as threatening the idiosyncratic features of lowland dialects (Grzech, Schwarz et al. 2019).

Nevertheless, Napo province can be considered the most indigenous province in the country, with the highest proportion of residents (56.8%) who identify as indigenous. The overwhelming majority (91.8%) identify as Kichwa, with 1.3% also identifying as part of a specific Kichwa pueblo of the Sierra (INEC 2010).[8] Napo is also home to other indigenous groups, particularly Shuar, Huaorani, and Andoa (now Kichwa speaking), who are mostly concentrated in the southeast corner of the province, and each comprise less than 1% of the indigenous population. In addition, there is a rapidly growing Afro Ecuadorian population, mostly migrating from coastal provinces, that comprises 2.8% of the total population (INEC 2010).

Notwithstanding its geographical proximity to Quito, the mountainous terrain kept Napo relatively isolated from the rest of Ecuador. Missionization was sporadic until the 1920s, when Italian Josephine missionaries were invited by the state to "civilize" the region (Oberem 1980). No major highways led to Napo until the discovery of oil in the 1970s, making what was once a

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[8] In another example of erasure, the 2010 census only included "Sierra Kichwa" as an option for Kichwa nationality, so it is uncertain how many residents in the census would have considered themselves Amazonian Kichwa.

days long trip take only hours (Erazo 2013). The construction of missionary boarding and day schools in the 1960s and 1970s encouraged previously mobile Kichwa families to establish permanent settlements around schools (Erazo 2013). In addition, national agrarian reforms in the 1960s and 70s led to widespread settler colonization by mestizos and highland Kichwa in lands considered "unoccupied" by the state.[9] In the early 2000s, large reserves of heavy crude oil were discovered, which increased extraction efforts close to Archidona and Tena. This also increased tensions in Napo Runa communities over environmental impacts and promised financial resources from oil companies (Erazo 2013, Uzendoski 2018). However, the crude was too costly to process, and extraction around Archidona and Tena ended in 2015 (Uzendoski 2018).

All of these forces of change led to a very recent and rapid transition towards urbanization and the market economy that continues to this day. This has had profound effects on Napo Runa culture, language, and diet. Many of these shifts are visible within only three generations (Muratorio 1998). In many of the Kichwa families I encountered, the grandparents (roughly 65-75 years old) were monolingual Kichwa speakers with some passive fluency in Spanish. Those who had some fluency/literacy in Spanish learned as adults or attended the first mission schools. Most still woke before dawn to drink unsweetened Guayusa tea and preferred *runa mikuna* [Kichwa food] such as chonta palm fruit, *aswa* [manioc chichi/beer], grubs, and bitter herbs. They grew up in small familial settlements with frequent travel to hunting and agricultural lands. Their children (roughly 35-50 years old) had several years of formal schooling and tended to be fully bilingual in Kichwa and Spanish. They worked to varying degrees in cash crop agriculture and wage labor. With more consumption of *mishu mikuna* [mestizo food] such as rice, fried foods, and soft drinks;

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[9] This led to some land dispossession for many Napo Runa families, who often did not have formal legal titles to the land their families had long occupied.

this generation was experiencing a dramatic increase of diabetes and other non-communicable diseases. The grandchildren (up to roughly 25 years old) were mostly monolingual Spanish speakers with some passive fluency in Kichwa. Their families expected them to earn a high school diploma. Many preferred *mishu mikuna*, and were often teased by older family members for putting sugar in their *aswa* and Guayusa tea (if they drank them at all). However, many of the older members of this generation are increasingly participating in linguistic and cultural revitalization initiatives including indigenous beauty contests and Kichwa radio programming (see Ennis 2019).

Many households combined occasional small-scale agriculture with some form of wage labor, with indigenous communities becoming increasingly involved in the market economy (Uzendoski 2005). Be it agriculture, the informal economy, or small business, 46.2% of the population of Napo was self-employed (INEC, 2010). Extractive industries in oil and rock mining are important employers, but have contributed to environmental contamination and flooding. As an alternative source of cash income, many indigenous communities have turned to ethno and eco-tourism (Rodriguez 2008). However, the largest formal employer in Napo is the government (INEC, 2010).

Recent urbanization means many communities lack basic public infrastructure, with only 59.4% of homes connected to the public water supply and only 43.2% connected to the sewage system (INEC, 2010). While highways and urban roads are paved, landslides are common during the rainy season and can cut off all transportation to any other major city (Quito, Baeza, and Puyo) for days at a time. The urban centers are surrounded by a ring of smaller communities connected to basic services but with unpaved roads. Beyond that are more rural communities with some basic amenities, reachable by a network of private bus operators, taxis (typically pickup trucks capable of traversing rough dirt roads), and water taxis (long outboard motor canoes). The more isolated communities can only be reached by canoe or water plane.

Tena, the capital city of Napo, is the fourth largest city in the Oriente with a parish population of 33,934 in 2010 (INEC, 2010). Since the 1970s, the population of the city has increased dramatically. The canton of Tena now accounts for 60% of the population of the province, giving evidence to its recent importance as an economic and administrative center. Only four hours away from Quito, the city has become a major tourist destination. Situated at the juncture of the Tena and Pano rivers, Tena has become a popular launching point for white water rafting and both eco- and ethnotourism.

It is also an important logistical center for extractive industries in more remote regions, which indigenous activists took advantage of during the national indigenous uprisings in 2001. With widespread support of mestizo residents, Napo Runa blockaded the bridge between Tena and Puerto Napo to protest dollarization, neoliberal policies, and demand cultural rights. The blockade essentially stopped all commerce, particularly for the oil companies. Unlike other uprisings, this one was suppressed by national military forces and resulted in the deaths of four people. The events drew national attention to the plight of indigenous peoples in the Amazon, which had been largely ignored by both the state and other Ecuadorians (Uzendoski 2006).

Archidona is the second largest city in Napo, located only 20 minutes to the north of Tena. While it is now half the size of Tena, Archidona was once the biggest and most important city in the Ecuadorian Amazon. Established by Spanish explorers in 1560, it was the primary site of one of the largest indigenous rebellions against the Spanish. Led by the Quijos cacique Jumandy in 1578, the rebellion united highland and lowland indigenous groups (Oberem 1980). The rebellion ultimately failed, but Jumandy has become an important political symbol of resistance and decolonization for contemporary Napo Runa in the region (Uzendoski 2005). As the center of the Josephine mission, Archidona was the primary site of education and health services in the region until the mid 1960s. For an urban center, Archidona has a high concentration of indigenous residents, with 83.7% of the canton identifying as such (INEC, 2010). The area's indigenous identity has become a central aspect of tourism efforts supported by the municipal government, including festivals dedicated to Jumandy and the Chonta palm fruit, as well as a food court serving *runa mikuna* [Kichwa food] like roasted grubs and meat steamed in banana leaves.

For the purposes of this project, it is important to understand that the Napo Runa have a particularly long and fraught history of cross-cultural interaction. At the same time, their longstanding geographic isolation has both exoticized them as a cultural curiosity amongst other Ecuadorians and distanced them (for better or worse) from the governmentality of the state. Within the last 50 years the region has changed dramatically, which has had notable impacts on cultural practices and lifeways. The expansion of public healthcare services represents one of these mechanisms of change. Napo Runa are acutely aware of this friction, and often describe the loss of certain practices/knowledge in the younger generation in terms of *kungarina* [forgetting] the *ruku kawsay* [old ways of life]. Despite an ever more urgent concern for their future, they also recognize new opportunities and social supports through which they can support their families, communities, and culture.

Therefore, Napo Runa should not be viewed as mere victims of modernization. Instead, their continued existence is evidence of their long history of selectively incorporating and resisting outside practices/institutions in order to maintain what they most value (Whitten and Whitten 2008, Uzendoski and Whitten 2014, Bridges 2017). Contemporary examples include participation in the indigenous uprisings (Uzendoski 2006), Kichwa revitalization through bilingual music and radio (Ennis 2019), and international commercialization of Guayusa tea (Jarrett 2019). As I will show in Chapter 5, their response to Intercultural Health policies demonstrate the continued friction between maintaining valued cultural practices and incorporating new forms and expectations of living.

1.2.2.1 Health in Napo

The health of the residents of Napo Province is strongly tied to rapid shifts towards market integration, large-scale extractive industries, and greater access to social services. Of the indigenous groups in the Ecuadorian Amazon, the Napo Runa are the most integrated into the market economy (Houck, Sorensen et al. 2013, Lu 2013). Only a few decades ago families ate nutritionally complex foods grown in home gardens and dispersed *chagras* [swidden agriculture plots], gathered in the forest, fished from the rivers, and caught in scattered hunting lands (Uzendoski 2005, Houck, Sorensen et al. 2013). But reduced time (because of school and wage labor), limited access to land, restrictions on fire arms, and a shift towards cash crops in recent years has meant that Napo Runa families must now buy a significant amount of their food (Houck, Sorensen et al. 2013, Cummins, Pinedo-Vasquez et al. 2015).

This has shifted diets towards foods high in calories/fat and low in diverse nutrients, and has contributed to high rates of simultaneous stunting and overweight in children (Houck, Sorensen et al. 2013), and diabetes and heart disease in adults (MSP and INEC 2014). Many traditional foods such as white lipped peccary, manioc *aswa*, and catfish remain culturally important as both ceremonial/symbolic foods and markers of indigeneity (Cummins, Pinedo-Vasquez et al. 2015, Musante, Bridges et al. 2015). However, they are labor and time intensive and many communities now rely on more rural kin and informal market networks to acquire and prepare traditional foods (Cummins, Pinedo-Vasquez et al. 2015, Musante, Bridges et al. 2015). In addition, petroleum industries, illegal gold mining, and deforestation have raised mercury in fish to hazardous levels (Webb, Coomes et al. 2015).

For most communities in the region, the primary health problems are nutritional deficiencies, diarrhea, gastroenteritis, urinary tract infections, dental issues, parasites, respiratory illnesses, and accidents (Interview with MSP District Director, 2015;(Bridges 2017). Many of these stem from aforementioned changes in diet, as well as lack of access to safe drinking water and secure housing. However, in 2015 automotive accidents were the primary cause of death in the province. Other accidents such as drowning, snake bites, machete cuts, falls, and handling hazardous materials are also common (INEC 2010). Many of these accidents occur in settings where both indigenous and mestizo residents earn wage income including construction projects, monoculture (requiring pesticides), fumigation, and logging.

The Napo Runa medical tradition is based on ideologies of health and healing that differ in fundamental ways from biomedicine and the hegemonic mestizo culture. In brief, the Napo Runa worldview revolves around three interrelated beliefs, what Londoño Sulkin refers to as the "Amazonian Package" (2017). First is Perspectivism where no clear "man verses nature" divide exists, but rather "humanity" is seen as a relative experience for all species and spirits (De Castro 1998). Just as humans have complex emotions and social lives, so do animals, plants, and mountains in their own particular contexts and points of view (De Castro 1998, Whitten and Whitten 2008, Kohn 2013). Second is the social construction of human bodies through the sharing of vital substances. These substances include nutritional and ritual staples such as bush meat and *aswa*, but also an ethereal soul energy/strength referred to as *samay* [lit. breath] (Muratorio 1991, Uzendoski 2005). A Runa is made a healthy and legitimate member of society by fulfilling their obligations to provide and care for others through the exchange of these substances. Third is seeking out relationships with powerful Others to access their knowledge, vital substances, and external perspectives (Whitten and Whitten 2008, Uzendoski and Whitten 2014). These Others can include in-laws, other cultural groups, animals, plants, and forest spirits to name a few (Swanson 2009, Londoño Sulkin 2017).

Through these principles, *runa* life is marked by "Ecological Dialogism" where animals and spirits communicate and interact with human society, and humans in turn influence the natural world by embodying other species through song and prescribed behaviors (Nuckolls 2010). This ecological dialogism is a primary source for diagnosis, medicinal preparations, treatment, and prevention. On a basic level, individuals can influence their health through direct and indirect dialogue with plants and animals. For example, an herbalist can seduce plants to provide more potent sap (Swanson 2009). Similar to sympathetic magic, medicines are determined by their defining role in nature. *Virgin Mama Sisa* [virgin mother flower], for example, is a flower whose petals fall at the slightest touch. This "shattering" characteristic makes it ideal for inducing and speeding up labor as it represents the breaking of the amniotic sac.

This process is most clearly visible in the role of a *yachak* [lit. one who knows, shaman]. When someone is feeling unwell, for example, the *yachak* may drink *ayahuasca*[10], an entheogen that allows them to enter into the worlds/perspectives of other beings and communicate with them. The *yachak* then sings to the spirits/beings with whom he has relationships and asks for assistance. These Others help the *yachak* to diagnose the illness and find the proper treatment. Often, the *yachak* sucks out the illness and sends it away from the body by spitting and fanning it away with

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[10] A compound tea made of the Banisteriopsis caapi vine and the Psychotria viridis shrub. This combination in effect creates Dimethyltryptamine (DMT).

leaves. To give the sick person strength, the *yachak* blows forcefully on their head to give them *samay,* and may also prescribe them a particular diet or herbal remedy. Therefore, a person is made well through the sharing of *samay,* but also through the social ties/knowledge from spiritual others employed by the *yachak*.

More generally, Runa recognize that health is a continually shifting state. It can be maintained through vital substances, good diet, and fulfilling social roles. However, ignoring one's obligations could lead to "dark magic" where a *yachak* may send "spirit darts" to cause illness, or natural spirits/animals may cause accidents(Kohn 1992, Whitten and Whitten 2008). A number of medical specialties are recognized in Runa communities, and individuals often have multiple or overlapping skillsets. A *yachak* primarily heals through ritual cleansing of the body and home, but is often viewed with ambivalence or suspicion as they can send illnesses to others (Kohn 1992, Whitten and Whitten 2008). There are also those who specialize in herbal remedies, bonesetting/massage, and midwifery. These practitioners are sometimes described as *pajuyuk* [lit. one with a knack for/power of], who are seen to hold special powers for diagnosing and treating illness. *Paju* is seen as a finite commodity shared through embodied experience, and is an important mechanism for transmitting traditional knowledge (Muratorio 1991, Kohn 1992, Uzendoski 2005).[11] In Chapter 5, I will discuss ideologies of birth and the roles of Napo Runa midwives and other practitioners in more detail.

Biomedical services in Napo Province are largely provided by the national government. Over 65% of the population has no form of health insurance or affiliation, thereby relying on the MSP for institutional care (Censos 2010). For several years the only hospital in the region was the

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[11] *Paju* and *pajuyuks* are not well defined in the literature. See Bridges 2017 for a more detailed description

Stadler Richter Hospital in Archidona. When it was established in 1949 by the Josephine missionaries, the hospital provided only maternity and emergency services. It was expanded in 1965, and at the time of research offered several specialties and laboratory services coordinated by the Catholic Church in partnership with the MSP and international organizations. Still occupying the building from 1965, the hospital was in a moderate state of disrepair.

The Josephines also helped establish the MSP hospital in Tena, José Maria Velasco Ibarra in 1954. Initially a dispensary, it eventually expanded to become the largest hospital in the province. As a General Hospital, it offers multiple specialties and imaging services and is the primary referral hospital for the northern Amazon region. However, patients requiring complex specialties and care (ex. oncology, neurosurgery, intensive therapies) are transferred to Quito, a four-hour journey by car. During preliminary fieldwork in 2013 the hospital housed two rooms for free position birth with intercultural pertinence (or PLPPI rooms), designed to follow the 2008 Guide for Culturally Adequate Birth (see Chapter 3). As my interviewees explained, the rooms were used for storage as none of the doctors had been trained to use them. During fieldwork in 2015-2016 various portions of the hospital were unusable due to extensive renovations. However, the plans for the updated hospital included two updated PLPPI rooms and greatly expanded services throughout the hospital.

Napo Province forms part of MSP administrative Zone 2 (along with Orellana and Pichincha minus Quito). At the local level the province falls under the jurisdiction of MSP Health District 15D01. At the time of research the district operated 18 health centers, seven health posts, and the Tena Hospital. While health centers typically do not offer labor and delivery services, the disperse and often remote populations served by the MSP in Napo made the expansion of PLPPI rooms a priority. By the end of fieldwork PLPPI rooms were available in four of the health centers:

AMUPAKIN, Chonta Punta, Arosemena Tola, and Ahuano. Most of the health centers operated in buildings loaned or rented to the MSP, but a newly constructed Centro Type A was open in Tena, and there were plans to build a Centro Type C (with labor & delivery) in Archidona. Theoretically, patients would go to their local health post or sub-center for basic primary/preventative care and would be referred to a larger health center or the hospital for more advanced diagnostics or treatment until care could be referred back to the local sub-center. In practice, limited time and transportation meant many residents sought services directly from larger health centers or the hospital (see Chapter 4). This was especially the case for births and other emergencies, as the hospitals in Archidona and Tena only had one ambulance each.

Compared to other parts of the country, biomedical service utilization in Napo is very low. However, data around reproductive health demonstrate how quickly this is changing. In 2004, 29% of births in the Amazon were at home but this dropped to 21.9% in 2012 (MSP and INEC 2014). In 2010, only 62% of births in Napo Province were managed by biomedical professionals, but this had increased to 83% by 2016 (INEC, 2016).

While biomedical institutions and traditional Kichwa practitioners are the most salient healthcare providers in Napo, many other options are also available. Several Runa organizations (as well as individual entrepreneurs) sell prepared herbal teas, shampoos, and other *sacha* [forest] remedies. There are several naturalist pharmacies in Tena, as well as herbal/natural remedies sold at markets and in buses. Many ambulatory vendors I encountered often touted “holistic” products purportedly based on the traditional medicines of China and India. In addition, the tourist economy in Tena has fostered a growing “wellness” industry in the region, including yoga retreats, reiki seminars, and spa services.

For purposes of brevity, I have outlined here a distinct division between biomedicine, alternative medicines, and traditional Runa medicine. However, this belies the nuanced and complex ways in which Napo Runa and mestizos seek health and practice medicine. Many studies have tried to frame medical pluralism as a hierarchy of choice between distinct systems (Broom, et al. 2009; Gold and Clapp 2011). Yet, both Runa people and traditional practitioners have long incorporated biomedical, religious, and naturalist practices in their daily lives and medical itineraries (Whitten and Whitten 2008, Davidov 2010, Bridges 2017). Furthermore, Runa communities and individuals hold and enact multiple medical ideologies, constantly employing various frameworks to understand illness and achieve health. Many older Napo Runa have lamented the shift away from *Ruku Kawsay* [old way of life] towards more Western and biomedical perspectives of health and wellness. However, this is not a process of one medical system simply replacing another. In her study of a Napo Runa community, Bridges argues the incorporation of biomedical beliefs and practices actually serves to extend Runa repertoires. As she states, Runa create "enmeshed therapeutic ecologies" where "knowledges and practices intra-act and become something new" (Bridges 2017). In Chapters 4 and 5, I will analyze how these therapeutic ecologies are viewed by both biomedical and Runa medical practitioners. Furthermore, I will examine how the perceived value of these medical systems (and the gray areas in between) are shaped by the affirmative biopolitics of the state.

1.2.2.2 AMUPAKIN: Casa para la Vida

The primary research site was the Casa Para la Vida [House for Life] operated by the *Asociación de Mujeres Parteras Kichwas de Alto Napo* [Association of Kichwa Midwives of Upper Napo]. Abbreviated as AMUPAKIN, the organization is located in the Kichwa community Sábata just outside the city center of Archidona. The Association was founded in 1994 by María

Antonia Shiguango who dreamt of a center of Runa midwifery with traditional thatched roof buildings and materials that would promote and transmit Napo Runa medical knowledge and practices (Interview 2015). She found support from the organization Sacha Cawsay, which helped search for funding and established the legal status of the organization. In 1997, the Ecuadorian Red Cross agreed to coordinate the project, and land was donated by the city of Archidona. In order to establish legal contracts, AMUPAKIN was formally registered as part of FONAKIN (then FOIN), the Federation of Organizations of Kichwa Nationalities of Napo and member organization of CONAIE in 1998. By 2001, the Spanish Red Cross, the AECI (Spanish Agency for International Cooperation), and the Ayuntamiento de Madrid agreed to finance the project.

Construction was completed in 2003, with infrastructure to support traditional practices and ensure financial sustainability after external funding ended in 2005. The House for Life includes administrative offices, a small 10 bed patient ward, a "green" pharmacy, exam rooms, and a birthing room with support bars, birth chairs, and a rope suspended from the ceiling. Small cabins surround the building for the use of midwives completing their shifts, international volunteers, and tourists. A separate event space includes a kitchen and is meant to provide income through private rentals and catering services. As many of the midwives are not accustomed to cooking fully indoors nor the heat of cement buildings, they built a separate kitchen using traditional flattened bamboo walls, dirt floor and an open fire for cooking. In addition, the grounds feature an extensive medicinal plant garden and spaces where the midwives grow manioc, corn, and other staples to eat during their shifts.

At the height of the Red Cross period the association was comprised of roughly 60 midwives, 20 apprentices, and 10 administrative *socios* from a large portion of Napo Province, particularly the areas surrounding Archidona and Tena (Garcia 2005). Beyond maternity and traditional medical care, the midwives produced herbal cosmetic products, hosted events and tourist groups, and received volunteers from the Red Cross and Peace Corps. Although the Red Cross had discussed including physicians in the House for Life, they were unable to get approval or funding from the MSP (Garcia 2005). As was planned, in 2005 the Red Cross and external funders ended their roles coordinating the project so it could be fully run by the midwives' association. Internal disagreements within the organization and the lack of external support led to the near abandonment of the association and grounds from 2007-2009.

After a period of recovery, AMUPAKIN partnered with the MSP to provide intercultural services and primary care by establishing a health post on the site in 2011. The MSP occupied half the House for Life as a health post, but AMUPAKIN retained control of everything else. The services provided by the MSP varied over time, but during the research period from 2015-2016 they included: two dentists, two family physicians, a basic pharmacy, a nurse, and three TAPS. There was also a gynecologist who left three months after research began and was never replaced. The intention was to establish an Intercultural clinic, where patients could choose to be seen by the midwives and/or the MSP doctors who would in turn counter-refer to one another. In cases of birth, the midwives and an MSP physician would manage the birth together. In practice, the MSP clinic and midwife organization operated independently of each other, and the MSP doctors only participated in births when they occurred during clinical hours (discussed in Chapters 4 and 5).

The partnership between the MSP and AMUPAKIN was tenuous, and constantly shifting due to the high turnover of MSP administrators and medical professionals (see chapters 4 and 5). The agreement gave members of AMUPAKIN preference for staffing two positions in the puesto, generally as the pharmacy technician and receptionist. In addition, the MSP paid for utilities, but did not pay any form of rent nor remuneration to the midwives' association. It was also unclear who was responsible for maintenance of the buildings.

At the time of research, AMUPAKIN had 13 active midwives and six *socios* (family members who were apprentices and/or assisted with administration). They completed 48 hour shifts in rotating pairs, tasked with caring for any patients who sought care and maintaining the grounds. The midwives mostly resided in Kichwa communities surrounding Archidona, including Rukullacta, Rumipamba, Salazar Aitaca, Awayaku, Ayapata, Chaupishungu, Papanku, and San Pedro (the only community represented from Tena). The midwives charged nominal fees for services ($5-10 for *wayrashka* [cleansing], $35 for birth], but also provided care for free if patients could not afford them. Members were not paid for completing their shifts, but not fulfilling their duties could preclude their earning money from the association when it was available. The largest sources of income for the association were not from traditional medical services or products, but from event hosting, tourism, voluntourism/internships, and grants through governmental institutions and NGO initiatives (see Chapter 5).

1.3 Research Methods

This project was initially designed to identify how power and authority are negotiated during the practice of intercultural healthcare at multiple levels: daily clinic interactions, regional administration, and national policy. It was also designed to take into account the diverse perspectives of those participating in the programs and those who are not. While the project aimed to include the perspective of community members, the primary focus was to understand the viewpoints and enactment of Intercultural Health policies by the biomedical providers, administrators, and midwives involved in implementation. The majority of the research was conducted in Spanish, but a significant portion of daily interactions and interviews with older midwives and community members utilized varying degrees of Kichwa.

1.3.1 Preliminary Research

This research was shaped by two preliminary research experiences. The first took place in 2009 as part of an internship program through La Fundación Cimas in Quito. As part of that program, I interned at Jambi Huasi, a private intercultural clinic in Otavalo operated by the local indigenous federation. During that period, I collected patient data for the clinic, observed traditional and biomedical appointments, interviewed staff, and attended several conferences on Intercultural Health. I also attended meetings between obstetrical staff and traditional midwives working jointly in the recently established Intercultural Birth program at Hospital San Luis. In 2013, I conducted two months of preliminary research at AMUPAKIN while taking advanced Kichwa language courses at the Andes and Amazon Field School. During this preliminary research I observed meetings and training sessions at the clinic and conducted interviews with over 30 midwives, Kichwa and mestiza women, healthcare workers, MSP officials and doctors in Archidona and Tena about intercultural health policies and reproductive health in general.

1.3.2 Methodology

In order to understand the implementation and experiences of Intercultural Health in Ecuador, I employed multiple data collection techniques to gather diverse perspectives from the local community, regional actors, and national policy influencers. The primary methods employed were participant observation and semi-structured interviews.

To examine the discourses of national Intercultural Health (IH) policies, I performed extensive archival research of policies and public discourses from the MSP, indigenous organizations, WHO and PAHO. This includes social media posts of legislators and activists, including Tweets and blog posts. I also obtained IH training materials, reporting data, and policy documents from the Zonal MSP office. In addition, I interviewed MSP officials and indigenous activists about the application of IH in the new healthcare system. These included semi-structured interviews with two MSP administrators in the national Intercultural Health Office, three zonal-level Intercultural Health directors, and two indigenous rights activists, and informal discussions with several humanized birth activists. I also attended public events about Intercultural Health and Humanized Birth that featured talks by national legislators, physicians, midwives, and birth activists. These included a legislative forum on the proposed Humanized Birth Law, meetings held by the birth rights group El Parto Es Nuestro, and a colloquia on Intercultural Health held at FLACSO Ecuador.

At the regional level, I conducted semi-structured interviews with MSP professionals in charge of implementing national IH policies, as well as leaders of organizations working closely with traditional medical practitioners. Interviews with regional MSP administrators (n=4) focused on the challenges of interpreting and implementing national policies in Napo. I also conducted semi-structured interviews with the directors (n=3) of the Archidona and Tena hospitals, in addition to two gynecologists at the Tena hospital. These interviews centered on the implementation of IH policies (particularly PLPPI), local epidemiology, and the impacts of the healthcare transformation on secondary level care. I also conducted semi-structured interviews with directors of Fundación Sacha Warmi (a Kichwa women's collective operating private IH projects), the local directors of the Ecuadorian Red Cross, and the GIZ. In addition, I attended numerous public events related to health services and Kichwa culture. These included MSP events for promoting indigenous medicines, cultural festivals, *rendición de cuentas* [annual progress forums] of the MSP offices, and meetings of local health committees.

While P.S. AMUPAKIN[12] was the only health center in Napo with an official partnership between the MSP and Kichwa practitioners, it was not the only site where Intercultural Health policies were implemented. Given the recent implementation of PLPPI across the health district, I interviewed MSP providers at each MSP clinic that offered the service (n=5). I also interviewed traditional Kichwa practitioners (n=5) who were not members of the association about their views on shifts in Runa medicine use/practice, Interculturality in health, and formal inclusion of traditional medicines in the MSP.

To understand the perspectives of residents of Archidona, Tena, and the surrounding communities I conducted semi-structured interviews with small groups. Intended to be focus groups stratified by age and gender, the questions examined perspectives of traditional and biomedical care, considerations of when to access each type of care, and perspectives on current Intercultural Health policies. I made several attempts at conducting formal focus groups, but never garnered more than three participants per session (six participants total). Therefore, I consider these to be small group interviews rather than focus groups. The first time, I recruited through a women's health club and the community elementary school. The second time, I recruited through snowball sampling and public radio ads. Members of AMUPAKIN, clinic staff, and others who

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[12] When referring to the MSP clinic I will use the name used by the health district: Puesto de Salud AMUPAKIN (P.S. AMUPAKIN). When referring only to the midwives' association I will use simply AMUPAKIN.

helped recruit participants noted they had faced similar challenges in the past. They felt many community members, especially those outside of the immediate urban centers, were hesitant to participate in meetings/events outside of their communities. They were seen to conflict with obligations at home or work, especially given the additional time needed to walk/bus to the municipal building where I had been given space to conduct the focus groups. Such a time commitment was viewed as "not worth it" without some form of monetary or material compensation.[13]

With this feedback, I conducted additional small group interviews (n=4) of three to six people each utilizing the focus group questions. Two of these interviews were of Kichwa households, one with a Mestizo household, and one with a group of women attending a pottery event. These interviews were illuminating for myself and the participants, as they highlighted changes in medical beliefs/practices across generations.

I utilized multiple techniques to examine the daily activities of the midwives' association and the clinic, particularly participant observation, semi-structured interviews, and observation of clinical encounters. For the duration of the research period I resided in one of the cabins at the AMUPAKIN campus. This allowed me to be present for births and other traditional treatments that often occurred after the clinic had closed. It also gave me a deeper understanding of the full breadth of activities the midwives participated in to sustain the organization. Finally, my daily presence in and around the clinic gave me an intimate view of the formal and informal interactions between the clinic staff, midwives, community of Sábata, patients, and government officials. I participated in many activities and events with the MSP providers and the midwives. With the

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[13] IRB restrictions and University research protocols made direct compensation of participants infeasible. Focus group participants were offered a meal and raffle prize worth $20 for their participation.

MSP staff I joined several *brigadas* [medical brigades] into the surrounding communities, as well as community health checks of vulnerable patients with the TAPS. I attended a wide variety of events with the midwives including workshops on citizen participation and ethnotourism, NGO projects on ethnobotany, and political rallies.

I conducted semi-structured interviews with all medical practitioners at the clinic regarding their formation as providers, perspectives on local health and Runa medicine, experiences at P.S. AMUPAKIN, and views of Intercultural Health policies. For the MSP clinic staff this was a total of 11 interviews: three dentists, three family practice physicians, one obstetrician, one nurse, one pharmacy technician, one receptionist, and three TAPS. One nurse's aide declined to be interviewed. For AMUPAKIN, I interviewed all 13 active midwives and three *socios*. Two people are represented in both groups, as the receptionist was a midwife of AMUPAKIN and the pharmacy technician was a *socia*.

Finally, I observed medical appointments conducted by both the midwives and MSP providers. Patients who were 18 or older were recruited as they waited to be seen, and were asked permission to video and/or audio record the appointment. When possible, immediately after the appointment patients were interviewed about their experience, views of the MSP, use of Runa and other alternative medicines, and perspectives of Intercultural Health Policies. Eleven encounters with the MSP clinicians were formally observed: one dental appointment, seven appointments with family practitioners, and three outreach visits by TAPS. The TAPS visits were only audio recorded, as no video equipment was available at the time. For the midwives, eight medical encounters were formally observed. One patient declined audio and video recording during the encounter. Three patients were not interviewed immediately following the encounter (see section on limitations). When I attempted to contact them later one declined to be interviewed, and one could not be reached. In total, these encounters were three births, three prenatal checkups, one *limpia* [ritual cleansing], and one treatment for digestion problems. One patient was recorded for both a prenatal checkup and a birth, which was the only birth to take place at the patient's home. Several more births, prenatal appointments, and treatments were observed, but not recorded due to delays in MSP research protocol approval. In addition, I conducted interviews with six women who were recovering from birth at the Tena hospital, but was not able to observe births there due to additional restrictions in place during hospital renovations.

1.3.2.1 Ethical Considerations

The research methods and consent procedures were approved by the University of Pittsburgh Internal Review Board, the Universidad San Francisco de Quito's Ethical Review, and the Ethical Committee for Human Research (CIESH), part of the MSP. In order to preserve the privacy of research participants I have used pseudonyms both during data collection and writing. The only names in this dissertation that are not pseudonyms are of people whose roles in their organizations are widely known and publicized internationally. While this distinction applies to several of the midwives, I have opted to only use their real names when referring to the history of the organization. Elsewhere, I have used pseudonyms to protect their identities as they discuss topics that are much more sensitive and personal.

Another concern, of both myself and the traditional practitioners I interviewed, was over the intellectual property of ethnobotanical and ethnomedical knowledge. The Ecuadorian Amazon, and the Napo Runa in particular have been important sources of ethnobotanical research (Oberem 1980). AMUPAKIN has participated in several ethnobotanical studies over many years and have become increasingly suspicious of researchers who conduct small studies, then break all ties with the association. This closely mirrored what Davidov (2013) noted in another Napo Runa community, where bioprospecting was viewed as both financial and cultural exploitation. As will be discussed in Chapter 5, these concerns are further heightened by the increasing application of traditional birthing techniques in biomedical institutions.

Although not yet well researched, there is growing concern over the widespread appropriation of indigenous birthing techniques and ritual practices by the humanized and natural birth movements (Vega 2017). While preparing for the birth of my own daughter between conducting research and writing this dissertation, I was struck by the frequent use of *rebozos*[14] and other nominally indigenous techniques as proof of a hospital or nurse-midwife's holistic approach to natural birth. I was concerned not only about the pay discrepancy between these biomedical professionals and the Mexican midwives who originated this practice, but also the loss of its ritual significance and even practical skills/knowledge of its complex use. For these reasons, I purposefully limit the details provided about ethnobotanical and ethnomedical knowledge. I only discuss only specific plant species or practices that are already widely published, and only describe ethnomedical practices in the minimal amount of detail required for the reader to understand.

1.3.2.2 Data Analysis

After data collection was complete, all field notes, audio files, video files, and supplemental materials were imported into MAXQDA for data management and analysis. Audio and video files were transcribed using F5, and coded in MAXQDA. Codes were created both deductively and inductively using the constant comparative approach (Bernard 2011). A priori codes included cultural change, cultural appropriation, indigenous rights, natural birth, biomedical supremacy,

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[14] A woven wrap traditionally used by Mexican midwives to support a mother in prenatal, birth, and postpartum care.

inclusion of traditional practitioners/biomedical providers, inclusion of traditional practitioners/biomedical providers.

However, as the research began the original research methods and questions seemed inappropriate for what was occurring at the research site. Thus, during research the analytical emphasis changed towards general perspectives of Interculturality in health, institutionalized medical pluralism, and changes in the national healthcare system. After data collection was complete, I began more intensive coding and analysis of the data. As I did so I was surprised by the widespread concern of nearly all my interlocutors about biopolitical controls of both Runa and biomedicines. They were especially concerned with how these increased controls fit in with the *Buen Vivir* objectives and expectations of citizenship of recent government reforms. Therefore, a second round of coding and analysis was completed based more heavily on the grounded theory approach (Corbin and Strauss 2008). The guiding questions of this second analysis were the following:

1) How do interlocutors view Intercultural Health as affirmative biopolitics (or not)? How does this relate to their views on the indigenous movement and government reforms?
2) How do interlocutors view and participate in the implementation and evaluation of Intercultural Health? How do they perceive the impacts of those methods on themselves and others?
3) What are interlocuters' personal experiences in their role as biopolitical subjects/enforcers? What conflicts do they experience within those roles?

Some of the a posteriori codes generated through this approach include participatory citizenship, statistics of care, role of traditional practitioners, and co-responsibility for health.

1.3.2.3 Limitations

There were several limitations due to the nature of activities at the field site, and a significant delay in obtaining final approval from the MSP ethical review board. First, activities for both the clinic and midwives' association were often sporadic and last minute. On one hand, this made it difficult to schedule interviews in advance, as they frequently had to be postponed by the interviewees (and on a few occasions by myself). This also meant that at times I was not able to bring proper audio or video equipment with me during critical moments. Care encounters with the midwives were particularly unpredictable, which made it difficult to capture a full encounter from start to finish. It was a common occurrence that I would enter a room or building to see a consultation had already begun before I arrived. For some of these instances the encounter was far enough along that it was inappropriate to interrupt to ask for consent for formal observation/recording. In addition, I felt it unethical to interview mothers immediately following the birth of their child, or to follow their families if they were transferred to the hospital while in labor. This created additional challenges of finding and interviewing them if they were transferred or if they returned home more quickly than expected.

In addition, not long before the research period began the MSP instituted a new ethical review process for clinical research. Approval for interviewing MSP staff was delayed by four months, and full approval for observing biomedical care encounters was delayed by eight months. This significantly limited my ability to observe and interview those patients. I am grateful to the District Health Director, who recognized my plight and was able to authorize the staff interviews while full approval was pending.

Finally, the recruitment challenges for the focus groups have meant that some populations and perspectives are likely underrepresented. Most notably are the perspectives of men. While most people who sought care from the midwives or doctors were female, it was clear from my informal discussions with community members that men were active participants in deciding where and how their families accessed medical care. Likewise, the emphasis of IH policies on maternal health meant I largely focused on the perspectives of midwives, which limited the input of other traditional practitioners. In addition, my community data reflect an overwhelming majority of perspectives from Kichwa people living in peri-urban communities. This accurately reflects the patient population served by the P.S. AMUPAKIN. In the future, it would be useful to more extensively include the perspectives of people from the urban centers of Archidona and Tena, who are more likely to be mestizo.

1.4 Summary of Chapters

This research examines Intercultural Health policies as an attempt at affirmative biopolitics through state healthcare services. To discuss the multiple ways in which affirmative discourses are understood and negotiated at various points of policy design, implementation, and reception I have divided this dissertation into six chapters. This chapter has provided an introduction to the research site, methodology, and the national historical context of political reforms under the indigenous rights movement and President Rafael Correa.

In Chapter 2, I discuss the broad theoretical frameworks that informed the development of Intercultural Health policies and guided my analysis. This includes research related to biopolitics, politics of recognition, and the inclusion/exclusion of indigeneity in healthcare. In that chapter I also propose my own theoretical framework for analyzing affirmative biopolitics.

Chapters 3 through 5 focus on the perspectives of actors in different levels of Intercultural Health policy design and implementation. In each of those chapters I address the socio-political contexts shaping the work of those actors, their perspectives on the affirmative discourses of the state, their role in policy implementation, and their subjective experiences of working in those roles. The analysis of these chapters is framed by the four proposed components of affirmative biopolitics, providing a direct comparison of how affirmative biopolitics are experienced and enacted through varied roles in policy making and healthcare provision.

In Chapter 3, I examine the roles of activists and national MSP administrators in creating the policies and measures of Interculturality in health. I examine how policy makers contend with the ways their role as "standard setters" can prioritize the rights of one group over another and may undermine the cultural value of the traditional medicines they are tasked with supporting. At this level, international movements for indigenous rights, health development, and humanized care significantly shape the ways policies are developed and perceived. That chapter includes a review of the historical development of Intercultural Health policies in Ecuador. In Chapter 4, I discuss the roles of local MSP administrators and biomedical professionals as they implement Intercultural Health policies in Napo Province. As such, I explore the ways in which their work as the principle "data generators" is limited by existing structural challenges and a hierarchy of biopolitical agendas within the MSP. In Chapter 5, I analyze the perspectives of traditional medical practitioners as they wrestle with the potential benefits and pitfalls of becoming biopolitical agents of the state. For them, the challenges of Intercultural Health lie in fundamental differences of what Interculturality and living well mean and how they can be achieved. They question whether they are being valued as cultural/political symbols or legitimate medical practitioners, but are also searching for ways to continue their practices as the value systems of their own communities change drastically

In the final chapter, I compare the ways affirmative biopolitics are perceived and negotiated within each of those groups. Instead of a clear state vs subaltern divide, I detail how conceptions of the good life and Interculturality are actively negotiated at each level of implementation. In doing so, I argue for a more nuanced theoretical analysis of biopolitics in health. The chapter concludes with a brief epilogue and implications for future study of affirmative biopolitics and Intercultural Health.

2.0 Chapter 2: Theoretical Orientations

This research examines Intercultural Health policies as a case study of affirmative biopolitics. In this chapter, I outline the theories of Foucauldian biopolitics, politics of recognition, and indigeneity in healthcare that guide my analysis. In doing so, I unite overlapping insights from the fields of biopolitics, post-colonialism and indigeneity in the Americas, (inter)national development, medical pluralism, and culturally appropriate healthcare. Due to the interdisciplinary nature of these topics, this chapter touches upon perspectives from anthropology, history, political science, public health, and biomedical practice. This cross-disciplinary approach is both

To frame my analysis (and future studies of affirmative biopolitics), I argue affirmative biopolitics that seek to legitimize previously marginalized forms of life and citizenship, are defined by four key components. First, to be affirmative, state biopolitics must seek to expand the definition of biocitizenship by incorporating **plural lifeways** in the imagined community of the state. Second, this affirmative shift is propelled through broad **networks of change (**including NGOs and activist groups) that exert external pressure on the state. Third, the **participatory governance** of previously marginalized groups must enable formal influence on the policies and structures that reify state biopolitical agendas. Fourth, notable **adjustment of policies and structures** of governmentality must be made to rectify previous processes of control and exclusion of marginalized groups.

In Section 1, I introduce theories of biopower, biopolitics and biocitizenship this research engages with to develop this framework for analyzing the possibilities of affirmative biopolitics in real-world scenarios. In Section 2, I examine the positive and negative implications of formal policies recognizing indigenous (and other marginalized) peoples as part of the nation state, including the concept of *interculturalidad* [Interculturality] and the various debates over its meaning and efficacy. In Section 3, I address the ways in which healthcare services have been used as a mechanism of biopower over indigenous bodies, and to encourage and discourage indigeneity in the imagined identity of the nation state and international development agendas. This includes discussions of medical pluralism and culturally appropriate biomedical care. Finally, in Section 4 I provide a more detailed description of the proposed components of affirmative biopolitics that guide my analysis in the subsequent chapters.

2.1 Biopolitics and Biocitizenship

As an explicit state definition of a Good Life based on statistical measures of population well-being, the intertwined politics of *Buen Vivir* and Interculturality in Ecuador present an important opportunity for analysis through theories of biopolitics. As proposed by Foucault (1990), modern forms of governance should be understood through the combination of disciplinary power that is often repressive and individualized, and biopower that "exerts a positive influence on life, that endeavors to administer, optimize, and multiply it, subjecting it to precise controls and comprehensive regulations" (Foucault 1990). Unlike disciplinary power, biopower regulates life at the population level through networks of social, economic and political control that "foster life or disallow it to the point of death" (Foucault 1990, p. 128) through overlapping material coercions that stratify access to social and economic resources (Foucault and Ewald 2003).

Central to biopower is the idea of biopolitics, a political rationality that monitors, tracks, and quantifies life at the population level; for example, through rates of birth, marriage, and mortality (Foucault 1990, Liesen and Walsh 2012). In Foucault's formulation these types of biopolitical measures constitute a double-edged sword that creates boundaries between lives deemed valuable and worthy of support by the state versus lives to be neglected or actively discouraged (Foucault and Ewald 2003). In Ecuador, the biopolitical rationality of the state is evidenced through the *Buen Vivir* Development Plan, which directly ties the progress of the nation to the achievement of statistical goals in health, education, and markers of indigenous identity such as language spoken at home. Universal healthcare services, international health initiatives, and Intercultural Health policies form part of the systems of governmentality that reinforce the kinds of lives thought necessary to achieve those goals.

State biopolitics are political regimes that shape what is considered to be the ideal life, or the ways in which life should be lived in order to be considered a valuable member of society. These discussions of the "Good Life" or "life as such" thereby focus on what Fassin calls "biolegitimacy"- the power over what kind of life should be lived, by whom, and for how long (Fassin 2009). As Corsin-Jimenez (2008) notes, these biopolitics of the Good Life inevitably combine ethical values of social equality/inequality with concepts of personhood and ways of living. The biolegitimacy of certain lives over others by the state creates assumptions of a "model citizen" who fulfills expected norms and obligations to achieve the Good Life (Dean 2002, Nichter 2008, Munsterhjelm 2013, Happe, Johnson et al. 2018). Through the incorporation of Interculturality in the public healthcare system (and beyond), the policies of the Correa administration attempted to recognize indigenous strategies of well-being and traditional medicines as legitimate methods of achieving the Good Life. However, as I discuss in the following chapters, this newfound acceptance of indigeneity coincided with increased obligations or "co-responsibilities" that reinforce biomedicine as the primary mechanism of biocitizenship.

As Nichter describes, biocitizenship can be defined as "the policies of entitlement and deservedness" that articulate "what human rights are recognized…and who gets excluded or sacrificed when health resources are rationed or restricted" (Nichter 2008). Sub-sects of the population deemed incapable of fulfilling their obligations, or viewed as undeserving of the Good Life are then excluded from the full rights and recognitions of citizenship (Nichter 2008, Munsterhjelm 2013). In this way, biopolitics are framed as top-down constructs through which the state compels individuals to indirectly govern themselves within biopolitical agendas (Rose 1996, Dean 2002, Foucault 2008). Thus, theories of biopolitics and biocitizenship have been primarily concerned with examining state imposition and control of lives "from above," contrasted by resistance and alternative forms of citizenship "from below".

Forms of resistance against biopolitical controls and coercions are generally theorized in three ways. First and most commonly, they are examined as diffuse and limited forms of resistance and agency, what Foucault (2007) refers to as "counter-conducts" that question the status quo by doing things differently- refusing to act as a compliant, responsible, or self-governing subject (Seppälä 2014). In addition, resistance to state biopolitical agendas has been analyzed through biocitizenship "from below" that creates alternative collective memberships (Rose and Novas 2005, Raman and Tutton 2010, Happe, Johnson et al. 2018). This type of resistance has been understood through the ways individuals self-identify and collectivize under shared biological categories (what Rabinow (2005) calls "biosocialities") to petition the state and institutions for additional rights and resources (see also Petryna 2002, Rose and Novas 2005, Rabinow and Rose 2006). The most radical form of resistance against biopower has been posited as a complete (but unlikely) overthrow of the state and a re-appropriation of its power, such as "off-grid" and other autonomous communities (Negri and Hardt 2000, Lilja and Vinthagen 2014). As Lilja and

Vinthagen state, “Resistance against biopower tries to avoid the managing of population policies and institutions by acting differently, in subcultures, and by cultivating a different set of values, practices and institutions” (2014).

While the statistical objectives in the *Buen Vivir* Development Plan and the radical demands of the Ecuadorian indigenous movement can be understood through these frameworks of biopolitical control “from above” and resistance “from below”, the adoption of indigenous and environmental political platforms in state policies also provoke important questions about the basic assumptions of common theories of biopower. First is that biopolitical agendas are static, reinforcing a rather consistent definition over what forms of life are sanctioned or not. However, the extensive development of state agendas in Ecuador based on social well-being and indigenous forms of sociality/conviviality (at least rhetorically) raises the questions of whether and how the objectives and methods of biopower can change. Second is that a monolithic state agenda is clearly contrasted against agency/resistance “from below”. Yet, the involvement of activists within governmental, institutional, and legislative reforms (such as drafting the new constitution) as well as the significant involvement of non-governmental institutions raises the important issue of how representational governance and civil society blur the lines between the state and the populace in both perpetuating and resisting biopower. Third is that resistance to biopower is inherently resistance against biopolitical agendas and controls. However, rather than resist biopolitical controls outright, the indigenous movement in Ecuador sought to change what was being counted, how it was valued, and how it was used to govern. For these reasons, this research purposefully incorporates critical perspectives of biopolitical theory, in particular those focused on affirmative biopolitics, and biopolitics beyond neoliberalism and the global north.

2.1.1 Affirmative Biopolitics and Biopolitics Elsewhere

A growing field of biopolitical analysis has begun to question how biopower can change through expanding boundaries of biocitizenship "from above" and establishing the biolegitimacy of previously marginalized groups. Predominant theories have largely explored biopolitics as an inherently oppressive force to be resisted, despite Foucault's (1990) assertion that biopower is both negative as a source of exclusion/control and positive as a means of fostering life (see also Catherine 2017). More recent scholars have argued biopolitics can be affirmative, as they can actively produce new forms of life, citizenship, and future worlds (Campbell and Sitze 2013, Catherine 2017). As Esposito argues, affirmative biopolitics should be understood as power "of life" rather than power "over life" (2008).

Using a metaphor of immunity, Esposito (2008) argues that modern biopolitics is defined by the tension between political unity and social plurality. While efforts to protect political unity and identity attempt to limit the threats of pluralistic communities, a process of "immunization" as protection necessitates a controlled tolerance of alterity thereby allowing for the possibility of legitimate alternative norms and livelihoods (Esposito 2008, Esposito 2011). For Hardt and Negri (2000), alternative possibilities of the Good Life are proposed and produced through the creative forces of diverse and interconnected relationships of activists, social media, organizations, and individuals (what they refer to as the "multitude") that influence the definition of the borders of both biopower and sovereignty more generally. They emphasize that while marginalized populations are seen to be excluded from/subordinated by the state, they are still participants in the biopolitical production of life through their global networks of culture and innovation (Hardt and Negri 2009).

These theories of affirmative biopolitics provide a critical departure from framing biopower as purely top-down, instead demonstrating the complex ways populations and marginalized groups can likewise influence and be incorporated within biopower (Catherine 2017). Likewise, they open the possibility of individual and collective resistance **within** biopower in addition to resistance **against** biopower. As Thompson posits, resistance must utilize the same technologies of biopower in order to create new possibilities (Thompson 2005). Thus, resistance itself fosters governance, as the parameters of dissent also shape the conduct of subjects (Odysseos, Death et al. 2016). In a similar vein, subaltern studies have underscored how resistance movements often adopt multiple strategies of intransigence and working with governments at the same time (Seppälä 2014). Therefore, resistance in affirmative biopolitical analysis includes attempts to change the boundaries of biopower by expanding the definitions of biocitizenship and the Good Life.

In this vein, some authors have argued for the possibility of democratic (and even communist) biopolitics, or biopolitics shaped by the governed which allow for a multiplicity of Good Lives and forms of biocitizenship (Prozorov 2016, Siisiäinen 2016). As Sotiris argues, democratically developed biopolitics would shift the focus of governmentality from individual discipline/coercion to collective responsibility (Sotiris 2020). I argue the politics of *Buen Vivir* and Intercultural Health in Ecuador are critical case studies for further development of affirmative and democratic biopolitics, given the vast transformations of democratic governance and the inclusion of Intercultural rhetoric in the reforms of the Correa administration.

While these discussions of affirmative and democratic biopolitics are largely theoretical, studies of biopolitics outside of its traditional settings of the global north have provided important insights into the many forms biopower can take. Scholars of developing countries have also argued their contexts of mixed economic policies, non-biomedical health systems, and political instability provide arguably messier but theoretically important case studies for biopolitical theory (Marsland and Prince 2012, Odysseos, Death et al. 2016). This has led to the call for a more general definition of biopolitics as the ways in which laws, social/professional norms, and/or political economies define, shape and value life (Fassin 2009, Marsland and Prince 2012, Campbell and Sitze 2013), with biocitizenship referring to the processes that prioritize access to rights and resources for compliant citizens (Plows and Boddington 2006, Nichter 2008, Happe, Johnson et al. 2018).

For example, scholars of the United States of America and Europe have generally argued that individual liberty is the apex of citizenship, and full liberty is dependent upon the ability to self-govern within biopolitical agendas (Rose 1996, Dean 2002, Barker 2010). However, scholars in/of Latin America have questioned these assumptions that personal autonomy and individual compliance are the core of biopower (Brotherton 2012, Morgan and Roberts 2012). As Morgan and Roberts argue, biopolitics of reproduction in Latin America are heavily influenced by human rights understood as a collective, rather than individual paradigm (Morgan and Roberts 2012). This point of critique is important for understanding the biopolitics of health in Ecuador, which have likewise been heavily influenced by demands for collective rights of ethnicity, gender, and health.

Similarly, recent critiques have noted the fallacy of equating biopolitics with neoliberal forms of governance. Neoliberal philosophies argue the state is inefficient as both an economic and social regulator. As such, neoliberal policies encourage economic deregulation, privatization, and reliance upon civil society to provide social services (Gardner and Richards 2019). Furthermore, the capitalism inherent in neoliberal governmentality is said to reduce human lives to calculations of economic value and risk management (Liesen and Walsh 2012, Gordon 2013). Therefore, neoliberalism has been viewed as the epitome of Foucauldian biopolitics, as limited government regulation necessitates individual self-governance in systems that favor productive citizens (Marsland and Prince 2012, Campbell and Sitze 2013). In recent years, this has led to a significant semantic overlap that conflates neoliberal governance with biopolitics generally (Prozorov 2016, Tierney 2016). Thus, any policy seen to promote self-governance or the marketization of the body/health are seen as inherently neoliberal (Prozorov 2016).

However, researchers of communist regimes question the assumption that biopolitics are inherently (neo)liberal imposition of self-governance, arguing for a return to Foucault's original construction of biopolitics as both governmental control and care, what he called the "biopolitical embrace" (Foucault 2007). Prozorov, for example, argues that Soviet biopolitics are based upon ideologies of positive transformation of human lives through government projects rather than individual action (2016). Brotherton likewise demonstrates how the collapse of the Cuban economy in the 1990s left its citizens to develop informal networks to access medical supplies and services. Rather than undermining socialist notions of collective well-being, many Cubans viewed the increase of individual responsibility as part of the fight to support state systems they wanted to remain intact (Brotherton 2008). As I will address in the following chapters, healthcare reforms in Ecuador have established a biopolitical agenda constructed on co-responsibility for health between individuals/communities and the state.

Finally, studies of biopolitics in third world countries have called for a more nuanced analysis of the relationship between biopower, colonialism, and inequality (Fassin 2009, Marsland and Prince 2012, Happe, Johnson et al. 2018). As Marsland and Prince note, because biopolitics inherently create inequality between those included and those excluded, attention must be paid to those who are living at the margins (2012). As scholars of Latin America have noted (albeit all too briefly), biopolitical paradigms in the region have been heavily influenced by international development agencies, but also interact in complex ways with postcolonial relationships of power and value associated with race, gender, class, and religion (Morgan and Roberts 2012, Smith-Oka 2013, Gamlin, Gibbon et al. 2020). This is certainly true of Ecuador as well, where the biopolitical agendas of *Buen Vivir* both build upon and challenge mechanisms of power that have shaped indigeneity from the time of colonization.

For this reason, this research purposefully combines insights from theories of biopolitics and theories of politics of recognition. This multi-disciplinary approach is both analytically and historically appropriate for examining the frictions inherent in Intercultural Health policies. Theories of biopolitics have largely focused on political rationalities and mechanisms of governance in Europe and North America. The characteristics of those states, such as relatively long economic and political stability, has contributed to both theoretical assumptions and practical perceptions of how biopower and its mechanisms function. In contrast, the more volatile political and economic contexts of Latin America are clearly distinct from the "traditional" contexts of biopolitical analysis. Arguably, forms of governance based on biopolitical rationality are fairly recent in the region, having become increasingly important through the influence of international agencies founded upon the methods of governance and statistical evaluation in their home countries. Instead, scholars in/of Latin America have understandably focused on the shifting politics of recognition that span administrations and seek not only to tolerate difference but to alter postcolonial structures of power and value.

The rise of Intercultural policies in Latin America is a defining historical moment where an increased emphasis on biopolitical rationality and on decolonial forms of governance have coincided and combined in complex ways. It is a clear example Tsing's (2005) description of the "friction" of globalization where awkward engagements and makeshift links are constructed across radically different perspectives and intents. As I will demonstrate, Intercultural Health policies are part of an explicit attempt to create a decolonial biopolitical rationality that legitimizes indigenous ways of life while also enforcing more specific (and restrictive) expectations of proper citizenship.

2.2 Politics of Recognition and Alternative Development

For scholars of subaltern groups, such as indigenous peoples, analysis has centered on post-colonial structures of power rather than biopower more broadly. With the rise of various rights movements and related "inclusive" political rhetoric and reforms, scholars have analyzed the implication of new "politics of recognition"[15] through which states embrace or highlight indigenous heritage. This body of research examines whether and how political agendas/normative principles that explicitly recognize culturally distinct groups as part of the imagined community of the state may question or uphold postcolonial inequality.

As many scholars have aptly noted, the definition and application of politics of recognition vary dramatically from one actor or time period to another (Cortes Mateos 2011, Kymlicka 2013, Solano-Campos 2016). Multiculturalism, for one, sought peaceful nationhood through respect for diversity (Degregori 1999, Tubino 2002). Interculturality, the predominant paradigm in Latin

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[15] Other common terms include "politics of difference" Alarcón M, A. M., A. Vidal H and J. Neira Rozas (2003). "Salud intercultural: elementos para la construcción de sus bases conceptuales." Revista médica de Chile **131**: 1061-1065, Hale, C. R. (2005). "Neoliberal multiculturalism." PoLAR: Political and Legal Anthropology Review **28**: 10-19, Kowal, E. (2008). "The Politics of the Gap: Indigenous Australians, Liberal Multiculturalism, and the End of the Self-Determination Era." American Anthropologist **110**: 338-348., "politics of belonging" Kirkham, S. R. (2003). "The politics of belonging and intercultural health care." Western Journal of Nursing Research **25**: 762-780, Browne, A. J., V. L. Smye and C. Varcoe (2005). "The relevance of postcolonial theoretical perspectives to research in Aboriginal health." CJNR (Canadian Journal of Nursing Research) **37**: 16-37., and "diversity paradigms" Solano-Campos, A. (2016). "Models of diversity in the Americas: Avenues for dialogue and cross-pollination." Multiculturalism and Interculturalism: Debating the Dividing Lines: 178-200..

America, prescribes open, equal, and mutual dialogue between culturally different groups that can create a shared benefit for all (Fernandez Juárez 2010).[16] However, even a singular paradigm of politics of recognition contains a multiplicity of meanings and applications. Cortes Mateos notes this "discursive clash" stems from the varied involvement of NGOs, international groups, indigenous activists, and the state; each with their own interpretations and agendas (Cortes Mateos 2011). I divide this clash into three broad fields. Each represent both an analytical stance of academic critique and the modus operandi of actors attempting to operationalize politics of recognition "on the ground." Proponents of **radicalism** believe Politics of recognition have the potential to subvert historical power structures to create new forms of governance. In contrast, **critical** approaches decry Politics of recognition for cosmetic rhetoric that does not create meaningful change and becomes a mechanism of state control. Somewhere in between, **pragmatic** approaches view Politics of recognition as a necessary but not wholly sufficient tool for fostering relationships with diverse communities that help achieve progressive social, health, and economic gains. In the following sections, I examine these divisions within academic analysis, highlighting the proposed biopolitical implications of each. In the following chapters, I demonstrate how these conflicting discourses are enacted and experienced by policy makers, public health administrators, and traditional and biomedical providers.

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[16] There is significant variation in how scholars differentiate the terms Interculturality and multiculturalism. Some view them as distinct and conflicting concepts Tubino, F. (2002). Entre el multiculturalismo y la interculturalidad: más allá de la discriminación positiva <u>Interculturalidad y Política: desafíos y posibilidades</u>. N. Fuller. Lima, Red Para el Desarrollo de Las Ciencias Sociales en el Perú**:** 51-76, Walsh, C. Ibid.(De) Construir la Interculturalidad. Consideraciones Críticas desde las políticas, la colonialidad y los movimientos indígenas y negros en el Ecuador., others view them as regional variations of general diversity paradigms Dietz, G. (2009). <u>Multiculturalism, interculturality and diversity in education</u>, Waxmann Verlag, Cortes Mateos, L. S. (2011). "La Migracion Transnacional del Discurso Intercultural: Su incorporacion, aprobacion Y resignificacion por actores educativos en Veracruz.", and yet others use the terms interchangeably- or simply refer to both as multiculturalism Kymlicka, W. (2013). "Neoliberal multiculturalism?" <u>Social resilience in the neoliberal era</u>: 99-125.. To avoid confusion, I distinguish between the two and use "politics of recognition" to refer to diversity paradigms more broadly.

2.2.1 Radical Politics of Recognition

In general, radicalists laud the potential of politics of recognition to dramatically change the status quo of governance, particularly for marginalized populations. Especially during the initial embrace of Interculturality in Latin America, theorists and activists viewed Interculturality as more radical counterpoint to multicultural paradigms (Walsh 2002, Dietz 2009).[17] Multiculturalism was critiqued for merely tolerating social difference of clearly defined groups, using affirmative action to meet the goals defined by powers that be (Degregori 1999, Tubino 2002, Walsh 2002, Lopez 2009). In contrast, Interculturality emphasized mutual dialogue between unbounded groups, blurred by histories of mestizaje, to create shared modes of transformative action to create better lives for all (Degregori 1999, Walsh 2002, Mignone, Bartlett et al. 2007). By incorporating subaltern (namely indigenous) epistemologies, new social contracts could be created that would radically upend post-colonial inequalities and power structures (Walsh 2002, Alarcón M, Vidal H et al. 2003, De La Cadena 2010). In particular, Interculturality was seen as advancing anti-neoliberal forms of redistribution, while multiculturalism was critiqued as a mechanism of neoliberal states (Hale 2005, Martínez Novo 2014).

International pressure to adopt politics of recognition as well as critiques of neoliberal initiatives also paved the way for alternative frameworks of development inspired by indigenous epistemologies. The clearest example is that of *Buen Vivir* and *Sumak Kawsay* discussed in Chapter

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[17] A similar debate over radicality is taking place between proponents of European interculturalism versus multiculturalism Levrau, F. and P. Loobuyck (2018). "Introduction: mapping the multiculturalism-interculturalism debate." Comparative migration studies **6**(1): 13-13, Zapata-Barrero, R. (2019). Intercultural Citizenship in the Post-Multicultural Era, SAGE Publications Limited.. While interculturalism and interculturalidad have remarkable similarities, they have distinct genealogies and applications Solano-Campos, A. (2016). "Models of diversity in the Americas: Avenues for dialogue and cross-pollination." Multiculturalism and Interculturalism: Debating the Dividing Lines: 178-200.. Here, I will focus specifically on discussions of Latin American *interculturalidad* [interculturality].

1. As a development platform, *Buen Vivir* emphasizes several shifts from traditional development paradigms, including establishing sustainable and harmonious relationships with nature, valuing the well-being (physical, spiritual, communal) of people and *Pacha Mama* [Mother Earth] over economic growth, and building a shared social future through intercultural relationships (Mamani 2010, Villalba 2013). Thus *Buen Vivir* eschews Western forms of modernization, extractivism, and human/nature dualism (Villalba-Eguiluz and Etxano 2017, Beling, Vanhulst et al. 2018). Carl Death demonstrates that Andean countries pushed for tenets of *Buen Vivir* to be included in the Sustainable Development Goals (SDGs), the replacement and critical response to the Millennium Development Goals (Death and Gabay 2015). Similar to *Buen Vivir*, the SDGs promote measuring growth via broad understandings of well-being (via improvements in education, health, poverty, etc) rather than monetary transactions or domestic products (Vanhulst and Beling 2014, Death and Gabay 2015). As Death argues, the SDGs provide the potential for establishing a new era of global biopolitics based on progressive governmentalities (Death and Gabay 2015).

Proponents of radical forms of politics of recognition and alternative development emphasize their potential to challenge oppression and create new forms of governance (De La Cadena 2010, Escobar 2010, Walsh 2010). Citing Tully(2001), Kymlicka notes that politics of recognition can create space for indigenous and other minority groups to contest inequalities while also establishing their responsibilities as citizens to contribute to the state at large (Kymlicka 2013). This occurs through processes of "citizenization," where sub-nations (such as indigenous peoples) assert that

> (1) the present form of constitutional recognition of their identity constitutes non-recognition or misrecognition, (2) this state of affairs constitutes an injustice, (3) the proposed new form of recognition is just and well-supported by public reasons… and (4) recognition (and institutional accommodation) by the other members would render the overall constitutional identity of the society a just and stable system of social cooperation (Tully 2001).

For Interculturality, this entails an epistemological decolonization of the state, a “deliberate decentering of the dominant culture” so that the perspectives of indigenous peoples become “a starting point for inquiry” (Browne, Smye et al. 2005) to construct alternative modernities (De La Cadena 2010, Escobar 2010, Mignolo 2010). In turn, decolonial citizenization could uphold indigenous lifeways and maximize their potential (Lindroth and Sinevaara-Niskanen 2016).

In addition, by expanding concepts of human development to general well-being, these frameworks are said to advocate moral politics of “life as such,” focused on quality of life, over the target-driven development politics of “life itself” (Fassin 2007, King, Smith et al. 2009, Escobar 2010). This has begun to impact the mechanisms of biopolitics, with new research approaches operationalizing methods of measuring health outcomes more directly aligned with indigenous conceptions of well-being (O'Neil, Reading et al. 1998, Sibthorpe, Anderson et al. 2001, Godoy, Reyes-García et al. 2005, Walter and Andersen 2013). However, as the next section explores, this radical approach to Interculturality is largely theoretical.

2.2.2 Critical Politics of Recognition

Critics note the ways in which politics of recognition have been ineffective, specious, and detrimental to indigenous peoples. While many scholars initially framed Interculturality as a post-multicultural paradigm, they have become increasingly skeptical of the notion that Interculturality and *Buen Vivir* are truly post-neoliberal, post-developmental, and post-racial (Martínez Novo 2014, Radcliffe 2018, Gardner and Richards 2019). This has blurred the lines distinguishing Interculturality from multiculturalism, and as such this section frames the critiques of politics of recognition more generally. As Brown (1995) notes, the central weakness of any politics of recognition is that even when it is deployed for change, it cannot fully transcend the conditions of oppression that created the inequalities in the first place (see also Bretón, Cortez et al. 2014).

The most pervasive critique of nearly all politics of recognition and alternative development models is that they are merely cosmetic rhetoric that appeases minority/activist groups, but do not lead to any meaningful change in policy (Tubino 2002, Ruiz 2006, Walsh 2010, Death and Gabay 2015). In reference to *Buen Vivir,* Bretón calls this "conventional development redressed as an alternative" (2014). Interculturalidad and Buen Vivir in particular are viewed as overly utopic visions, that are too ambiguous and dynamic to be operationalized in a practical way (Flores Martos 2011, Bretón, Cortez et al. 2014, Villalba-Eguiluz and Etxano 2017, Radcliffe 2018). For example, while alternative development models propose more holistic forms of growth, it is unclear how that should be measured. As Death notes, the continued emphasis on “big data” has meant that the biopolitical primacy of statistics is even stronger in the SDGs than in the MDGs (Death and Gabay 2015).

A harsher critique is that states are insidiously co-opting indigenous/alternative models in order to avoid more radical changes, or even to obfuscate policies that increase inequalities and oppression. Escobar argues this stems from the tensions inherent in governments trying to harness the creative force of social movements while resisting challenges to the legitimacy/control of the state (2010). Mitchell notes that multiculturalism was a “tool of domestication” that used notions of national harmony to bring about neoliberal reforms (Dean 2002). For scholars of Interculturality, this is enshrined in Hale’s (2005) theory of “neoliberal multiculturalism” (Walsh 2010, see Becker 2011, Cubillo-Guevara, Hidalgo-Capitán et al. 2013, Lucero 2013, Martínez Novo 2014, Gardner and Richards 2019). By granting indigenous groups some control over select social services, Hale argues the state effectively limits their power to specific political spheres and can manipulate political opposition through bureaucratic negotiations (2005).[18] Several scholars have noted this process also “disciplines” indigenous peoples, separating them into permitted/pragmatic Indians vs radical/recalcitrant ones which then further divides the movements internally (Browne, Smye et al. 2005, Lalander 2010, Lucero 2013, Martínez Novo and Shlossberg 2018). Thus, Politics of recognition generally have been critiqued as forms of “democratic racism” (Kirkham 2003)and new forms of colonial dispossession (Hale and Reinao 2018) that can justify state violence (Browne, Smye et al. 2005, Martínez Novo 2014).

Regardless of whether Politics of recognition are manipulative or merely cosmetic, they can reify indigenous identities in interesting ways. For example, they emphasize a distinction between those “with culture” who require the help of those without, limiting changes to those who are seen as particularly indigenous or other (Cortes Mateos 2011, Fernandez Juárez 2011, Flores Martos 2011). This even occurs when indigenous groups are active participants in designing alternative policies. They are often limited to markedly indigenous policy spheres, and many aspects of traditional knowledge are excluded for being too “irrational” (Lindroth and Sinevaara-Niskanen 2016). Lindroth also notes how discourses of indigenous peoples as resilient caretakers of the earth reify the resilience of indigenous peoples and make indigenous peoples “saviors” of the planet, obscuring who caused the environmental degradation in the first place (2016). In addition, Interculturality and *Buen Vivir* romanticize rural highland Kichwa/Quechua/Aymara forms of indigeneity and rights demands that exclude other indigenous epistemologies, lifestyles, and forms of activism (Hidalgo-Capitán and Cubillo-Guevara 2014, Viola Recasens 2014).

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[18] For similar arguments related to indigenous groups in North America, seeJacklin Wayne, K. M. W. (2004). The Indian Health Transfer Policy in Canada: Toward Self-Determination or Cost-Containment? Unhealthy health policy : a critical anthropological examination. A. Castro and M. Singer. Walnut Creek, Calif., AltaMira Press**:** 215-235, Joe, J. R. (2015). The Changing Picture of Health for American Indians and Alaskan Natives. The World of Indigenous North America. R. A. Warrior. New York, Routledge..

Finally, participation of indigenous leaders in national or international policy development can alienate them from local needs, thus casting doubt on their cultural authenticity and authority both from above and below (Lalander 2010, Lindroth and Sinevaara-Niskanen 2016). In Ecuador this is epitomized by Correa’s strategy of deriding indigenous leaders as “golden ponchos,” a derogatory term for corrupt indigenous elites.

2.2.3 Pragmatic Politics of Recognition

Many scholars have recognized the potential of Politics of recognition for creating positive change, even it may not live up to its full radical potential. In practice, pragmatic views are often espoused by those working on the “front lines” of policy implementation who recognize the limitations of Politics of recognition but are dedicated to improving health, education, and economic outcomes. In many countries, politics of recognition have been linked with improved outcomes, and may have helped towards achieving the MDGs (Kymlicka 2013). In Latin America, *Buen Vivir* and Interculturality have resulted in legitimate policy shifts such as increased social welfare programs, new structures for community participation in democracy, indigenous control of various institutions, and processes of prior informed consent for extractive industries. While the impacts of these policies are debated, the reforms were in part a result of politics of recognition (Tubino 2002, Van Cott 2005, Escobar 2010, Kymlicka 2013). Furthermore, Politics of recognition have given indigenous peoples political footholds to strongly influence governance for the population at large (Tully 2014, Death and Gabay 2015), and have aided in the election of indigenous and socialist leaders in Latin America (Van Cott 2005).

In his discussion of citizenization, Tully (2001) summarizes the “pragmatic” viewpoint well. He argues the challenge of politics of recognition is that:

> (1) struggles over the mutual recognition of identities are too complex, unpredictable and mutable to admit of definitive solutions, and (2) the intersubjective activity of striving for and responding to forms of mutual recognition is an intrinsic public good of modern politics which contributes to legitimacy and stability whether or not the form of recognition demanded is achieved (p. 5).

This is highlighted by the fact that politics of recognition have now become an international moral standard of governance, marking the "advancement" of nation states (Kymlicka 2013). Even though countries espousing *Buen Vivir* still rely heavily on unsustainable development practices, Death notes their challenge to traditional development is considerable, and may begin to frame new agendas in terms of the "world we want" (2015). Finally, Tully suggests a shift in pragmatic and radical frameworks towards viewing politics of recognition as an ongoing iterative political process of incremental change (Tully 2001).

2.3 Indigeneity and Health

As one of the primary tools of governmentality, health services have been an important mechanism of national identity making and management of indigenous peoples. In particular, the relationship between the state and indigenous communities have centered on the "Indian Problem": the nearly ubiquitous question of whether, and how, indigenous groups should be included in the imagined communities of the state (Canessa 2005, Yashar 2005). During the colonial period, it referred to the need to align with or overpower native peoples of occupied and desired lands. In the wake of decolonization, it begged the question of how to incorporate a large, but highly stigmatized, segment of the population into the burgeoning nation. Both biomedicine and ethnomedicines have been important mechanisms of managing the Indian Problem and its effects. The following section examines the role of state health services in both excluding and including indigenous peoples and culture in nation. In general, the governance of indigeneity through health services has varied between these often overlapping strategies: genocidal elimination of indigenous peoples, attempts to assimilate them into the hegemonic culture, recognizing/celebrating indigenous culture, and “decolonization” efforts to expand indigenous self-determination (Kowal 2008, Death and Gabay 2015, Collingwood-Whittick 2018).

2.3.1 Limiting Indigeneity in Health

Throughout the world, colonial authority involved the making of the indigenous “Other,” both unworthy of full inclusion into Western society and in desperate need of its intervention (Comaroff 1993, Anderson 2007, Greene, Thorp Basilico et al. 2013). The subalternity of indigenous peoples was fueled by colonial biopolitics of “life itself”- scientific measurements of the base biological capabilities of native peoples (Greene, Thorp Basilico et al. 2013). Comparative physical measurements and statistical health inequalities were considered objective proof of the inferiority of indigenous peoples (Greene, Thorp Basilico et al. 2013) (Kumar 1997); (Vaughan 1991); (Walter and Andersen 2013)). As Kolopenuk states, this created authoritative discourses of racialized depravity that “not only led to individualized/ing bodily violation but also to producing Indigeneity conceptually in ways that biologize our dispossession from sovereignty as natural” (2018)

These colonial biopolitics were part of governments justifications to control indigenous bodies and their access to resources, shaping “life as such”. Ultimately, these controls forced many of the world’s indigenous peoples into more isolated and harsh environments (Young 1994, Cunningham and Andrews 1997) that reduced access to critical resources and culturally significant lands (King, Smith et al. 2009), causing malnutrition, and increased morbidity of various diseases

(Comaroff 1993, King, Smith et al. 2009, Greene, Thorp Basilico et al. 2013). Increased institutional surveillance of these potentially hostile indigenous peoples also furthered the racialization of disease prevalence and the "unhealthy" practices of native peoples that made them "culpable of their own misfortune," while obscuring the processes of colonialism that had dramatically changed indigenous livelihoods and health (Lewis 2018).

These colonial values have proven difficult to forget or ignore. Nearly ubiquitous colonial ideologies depicting native peoples as the literal embodiment of disease (Greene, Thorp Basilico et al. 2013) (Vaughan 1991, Kumar 1997, Zulawski 2000) and biologically hard-wired for alcoholism, hypersexuality, stupidity and degeneracy continue to be salient today (Browne, Smye et al. 2005, Anderson 2007, Gone 2007, Hawkins 2007, Larson, Gillies et al. 2007, Kowal 2008, Etowa, Jesty et al. 2011). Tait, for example, examines how Fetal Alcohol Syndrome is constructed as an "aboriginal epidemic," reifying constructs of indigenous immorality and violence that challenge the safety of white society (2000). Similarly, international population control campaigns intended to alleviate poverty were often driven by racial stereotypes of indigenous women as highly fertile but unfit mothers (Alderete 2004, Castro 2004, Smith-Oka 2013, Guerra-Reyes 2019).

Development discourses of indigenous peoples as the most marginalized, poor, and unhealthy subpopulation throughout the world equate to the strategic creation of helpless indigenous subjects at the mercy of their environment or socioeconomic contexts (Lindroth and Sinevaara-Niskanen 2016). Through statistical databases, biomedical standards, and scientific studies, international health organizations created what Escobar has referred to as a "politics of truth" that reify colonial stereotypes of unhealthy/dependent indigenous peoples in need of paternalistic intervention (Briggs 2002, Nichter and Lock 2002, Escobar 2011, Walter and

Andersen 2013). This strategic creation of helpless indigenous subjects is particularly salient in development discourses of indigenous peoples as the most marginalized, poor, and unhealthy subpopulation throughout the world (Lindroth and Sinevaara-Niskanen 2016). This rhetoric is so widespread and authoritative it has become integral in both etic and emic construction of indigenous identity (Deloria 1969, O'Neil, Reading et al. 1998, Browne, Smye et al. 2005, Tang and Browne 2008, Etowa, Jesty et al. 2011).

Post-colonial independence and the resulting rise of international development further reified the indigenous body as the site of national identity for new and developing nation states who saw indigenous peoples as impeding modernity (Zulawski 2000, Canessa 2005, Gone 2007, Kowalczyk 2013, Smith-Oka 2013). Overtly assimilationist policies included religious conversion, forced adoption to settler families, banning of indigenous languages and traditional medical practices, (King, Smith et al. 2009, Greene, Thorp Basilico et al. 2013). Although most governments have retracted such policies, many argue assimilation persists under the banners of “modernization,” “normalization,” and “development” (O'Neil 1989, Cunningham and Andrews 1997, Altman 2007, Escobar 2011, Smith-Oka 2013).

Recent critiques of assimilationism are often linked to vertical, “top-down” international initiatives focused on achieving targeted health outcomes in sanitation, reproductive health, and malnutrition (Bastien 1992, Cooper and Packard 1997, Escobar 2011, Basilico, Weigel et al. 2013, Smith-Oka 2013). Driven by cost-effectiveness, these programs generally assume biomedical or “scientific” interventions such as vaccination and pesticide eradication campaigns are universally effective (Bastien 1992, Cunningham and Andrews 1997, Lee 1997, Escobar 2011). Therefore, input from target indigenous communities, recognition of cultural differences, and ethnomedical practices are largely ignored or even discouraged (Bastien 1992, Pigg 1997, Escobar 2011, Basilico, Weigel et al. 2013). Failed programs were blamed on the extreme ignorance, deprivation, and passivity of the indigenous "targets," making further intervention all the more necessary (Cooper and Packard 1997, Lowy 1997, Pigg 1997, Escobar 2011). Smith-Oka argues that even more horizontal initiatives such as Conditional Cash Transfers are modern forms of assimilation that "meld biological citizenship and cultural belonging" (2013, p. 66). Through financial incentives, they entice destitute indigenous women to adopt mestizo and state-serving norms of motherhood (2013).

Policies that encourage cultural assimilation are often justified by the goal of eliminating health inequities. International standards such as the Millennium Development Goals mark indigenous peoples as necessitating change in order to "catch up," and provide significant political and financial pressure for nations to comply (Stephens, Porter et al. 2006, Smith-Oka 2013). Epidemiological statistics like maternal and infant mortality, fecundity, and stunting, create a moral politics of life as such, where nations are judged on their ability to eliminate health inequalities (Briggs 2002, Brotherton 2012). However, indigenous scholars note this means indigenous peoples must conform to white standards of living that define the top line of the graph (Kowal 2008, Stevenson 2012). Even when interventions are done with an earnest desire to help, these "regimes of care" are still implemented by biopolitical bureaucracies that prioritize numeric targets over cultural lifeways and values (Stevenson 2012). As Stevenson states, "when life becomes an indifferent value, it no longer matters who you are—simply that you cooperate in the project of staying alive" (Stevenson 2012,).

Generally, cultural assimilation is cited as a contributing factor to the ill health of indigenous peoples. Anomie has been tied to substance abuse, mental health issues, suicide, violence and injuries (Kunitz 1983, Young 1994, Tait 2000, Gone 2007). Market integration and radically changed indigenous diets have also catalyzed the epidemiological shift toward chronic disease, and increased exposure to environmental toxins (Kunitz 1983, Young 1994, Godoy, Reyes-García et al. 2005, Schanche Hodge 2015).

2.3.2 Incorporating Indigeneity in Health

Despite long histories of assimilation, nations have also actively recognized indigenous peoples and heritage as an integral component of national identity. The clearest example is official recognition of indigenous tribes and languages, although contemporary politics of difference ostensibly acknowledge indigeneity as a component of the imagined community of the state as well. Acknowledging indigenous peoples and cultural attributes can benefit states in several ways. Embracing unique cultural heritages can distinguish nation states from their neighbors, as well as from the cultural hegemony imposed by international development. Official recognition of indigenous peoples can also support state claims to their lands and territories. Notably, recent examples have even emphasized the presence of Native DNA in mixed heritage populations to support Quebecuoise nationalism (Leroux 2018), and Taiwanese claims against Chinese rule (Munsterhjelm 2013). Ironically, international development has incentivized nation states to adopt both assimilationist initiatives and those that recognize and embrace indigeneity. This even occurs simultaneously, when one initiative may promote indigenous rights or culture, while another may effectively target indigenous practices as particularly problematic.

In the modern era, state recognition of indigenous peoples has been heavily influenced by demands for indigenous rights. In general, rights-based discourses and activism argue certain government services and legal protections are so fundamental as to require universal guarantees-such as access to basic healthcare. Originally outlined in the charter of WHO (1946) and the

Universal Declaration of Human Rights (1948), the right to health was framed in a broad sense, including adequate standard of living, food, clothing, and welfare support (United Nations 1948).[19] Indigenous rights additionally argue for specialized rights based on shared status/identity and the long term impacts of targeted colonial oppression (Durie 2003, Alderete 2004, Stephens, Nettleton et al. 2005, Anderson, Crengle et al. 2006, PAHO 2008).

Decrees such as the International Labor Organization Convention of 1986 (ILO 169), and the UN Declaration on the Rights of Indigenous Peoples (UNDRIP) pushed for increased indigenous self-determination in health and development agendas, cultural and land protections, and the use social and biological measures of identity amongst other issues. Indigenous Rights movements have aligned themselves with broader demands of Human Rights and the right to health, arguing control over land, governance, and culture is necessary to improve health outcomes (Eades 2000, Durie 2003, Stephens, Porter et al. 2006). It is also argued that rights-based development paradigms improve the social and psychological well-being of indigenous groups through increased self-efficacy and veneration of "traditional" culture and knowledge, alleviating the effects of post-colonial relationships (Walters and Simoni 2002).

Rights frameworks were seen as means to overcome inequalities by demanding health based on a status independent of nationality (Morgan 2001, Farmer 2003, Basilico, Weigel et al. 2013). However, Agamben argues international law imposes ultimate responsibility on states, making it complicit in limiting rights only to recognized citizens (1998). The sovereignty of indigenous groups within nations has also been used to justify segregated and woefully underfunded health services (O'Neil 1989, Jacklin Wayne 2004, Browne, Smye et al. 2005,

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[19] This has been renewed through the Ottawa Charter (WHO 1986), General Comment 14 from the United Nations (2000), and summits in Cairo (1994) and Beijing (1995).

Anderson 2007). Farmer argues that rights discourses of "superstructural" groups (e.g. indigenous, youth, women) are culturally deterministic and fail to address "infrastructural" social and economic inequity, referred to as "structural violence" (2003). Similarly, these specialized claims may pit the rights, interests and health outcomes of native peoples against those of the public at large (Lalander 2010, Morgan and Roberts 2012, Smith-Oka 2013). Yet, as Backman states, "equal treatment does not always lead to equal access", so "asserting entitlement on the basis of difference" may be paradoxically necessary achieve equality in health (cited in Browne, Smye et al. 2005).

Both Human and Indigenous Rights discourses introduced three interrelated shifts in the operationalization of international health programs: focus on primary healthcare, community participation, and promotion of traditional medicines (Bastien 1992, Lee 1997, Towghi 2004, Basilico, Weigel et al. 2013). Reacting to the failure of vertical top-down programs, "horizontal" interventions providing basic healthcare were seen as the only way to achieve the right to health (Maynard 1974, Backman, Hunt et al. 2008, Basilico, Weigel et al. 2013).[20] Similarly, indigenous rights groups underscored dramatic health inequities to call attention to the destitute and neglected "fourth world" (Farmer 2003, Shaw 2005, Becker 2011). These pleas emphasized the need for basic health services for all, especially marginalized populations (Alderete 2004, del Cid Lucero 2008).

Community participation was viewed as a necessary component for achieving both universal primary healthcare and demands for indigenous self-determination(Bastien 1992, Alderete 2004, Backman, Hunt et al. 2008, Basilico, Weigel et al. 2013). For pragmatists,

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[20] The Alma Ata Declaration of 1978, added Primary Healthcare (PHC) as a necessary component to achieve "Health for All in 2000"

community participation was a means to encourage compliance and garner access to community land, labor, or other resources in order to complete a project more efficiently and sustainably (Rifkin 1996, Morgan 2001, Durie 2003). Activists, in contrast, aimed to empower indigenous peoples to intervene on their own terms (Rifkin 1996, Morgan 2001, Standing and Chowdhury 2008, Aizenberg 2014). Despite broad international support, a large body of literature highlights the challenges and failures of participatory approaches. Some of its limitations stem from "definitional disputes" between and "analytic complexities" of pragmatists, activists, and communities (Bastien 1992, Morgan 2001).

Beyond participation, health services for indigenous peoples are often a battleground for debates over self-determination. Demands for indigenous autonomy in healthcare include control over health expenditures and research approval processes, as well as the professionalization of ethnomedicines. Self-determination of health is said to increase community empowerment (O'Neil 1989, King, Smith et al. 2009), better tailor health interventions to community needs (O'Neil 1989, Jacklin Wayne 2004, Schanche Hodge 2015), foster cultural survival (Gone 2007), improve health outcomes (King, Smith et al. 2009), and reverse oppression and marginalization (Eades 2000, Smye and Browne 2002). State reparations toward indigenous self-determination overall (including self-governance and control over land) may also improve indigenous health through increased self-efficacy and reconnection with traditional livelihoods and values (Eades 2000, King, Smith et al. 2009). However, calls for autonomy over health often serve to remind post-colonial societies of the violence and failures of the state (Anderson 2007).

Many argue the extreme social and economic inequalities faced by indigenous communities can only be resolved with state resources and support (Young and Garro 1993, Farmer 2003, Jacklin Wayne 2004, Pesantes Villa 2014). Indigenous communities operating isolated health services cannot benefit from economies of scale (Schanche Hodge 2015), and they are often limited to rural areas/official members which neglects urban and mixed heritage populations (Browne, Fiske et al. 2000, Tait 2000, Jacklin Wayne 2004, Tang and Browne 2008). But, legal obligations for state funded indigenous services are unclear given the sovereign/semi-sovereign status of indigenous communities in many countries (Jacklin Wayne 2004, Joe 2015). In addition, state indifference, political unpopularity and failure to adequately enumerate indigenous populations also limit political will to support such policies (Gracey and King 2009). Uncontacted indigenous groups also spur debates over whether states are responsible for ensuring continued isolation (viewed as "voluntary") and/or providing health infrastructure to prevent disastrous consequences once "inevitable" contact is made (Magdalena Hurtado, Kim Hill et al. 2001).

Deloria warns that government support is "a dubious blessing, conferring some benefits but exacting a tremendous price in self-esteem and independence" (cited in Joe 2015). Even when governments give indigenous groups legal authority over health services, its control over funding and care requirements can obstruct meaningful change (Jacklin Wayne 2004, Joe 2015). Therefore, underfunded "self-determination" policies can be a cover for offloading costs and responsibility from government entities onto indigenous communities, serving to assimilate them by effectively removing specialized protections and services (Schanche Hodge 2015). In reference to Australia, Altman argues that recent government interventions of self-determination are neo-paternalistic in that they create structures of supervision, penalties and incentives to coerce indigenous peoples into behaving "normally" (2007). As Anderson states, "indigenous autonomy may deflect national interest. Put bluntly, you can have 'culture' or government health services, but not both" (2007).

Kowal argues this tenuous situation depends on a “postcolonial logic” based on a fragile balance of remediable difference and Orientalism (Kowal 2008). Positive and negative forms of Orientalism allow for the recognition of different identities and cultural values. Combined with remedialist efforts close the statistical “gap,” it identifies those aspects of difference that can remain and those that should be eliminated. Thus, forms of “sanitized alterity” such as traditional songs, dance, artwork, and clothing are encouraged by the state; while “unsanitized alterity” such as alcoholism and low prioritization of individual health must be changed to fit within the (typically white) standards of the nation (Kowal 2008). Postcolonial logic then leads to two possible approaches towards indigenous/national politics in health services. Either the state limits self-determination in order to likewise limit unsanitized alterity, or the state encourages self-determination/cultural difference because over-emphasis on remedialism may breed unsanitized alterity through the negative effects of anomie and cultural loss (Kowal 2008).

Official recognition of indigeneity in health is perhaps most visible in policies promoting traditional medicines and establishing culturally appropriate care in biomedical services. Both strategies have been considered necessary components of fostering community participation and broad access to primary health care (WHO 1978, Bastien 1992, Alderete 2004, Backman, Hunt et al. 2008). Lee (1997) demonstrates this shift in international paradigms resulted from developing nations critiquing the economic interventions and hegemony of biomedicine over traditional medical systems as neocolonialism (Bastien 1992, Alderete 2004, Brotherton 2012, Basilico, Weigel et al. 2013). It was also demanded by indigenous groups based on the overt discrimination and willful neglect of government health services (Farmer 2003, Alderete 2004, Jacklin Wayne 2004, Flores Martos 2011). In the 1970s, the WHO began advocating incorporation of traditional medicines, especially through training traditional birth attendants (TBAs) and indigenous community health workers (ICHWs) (WHO 1978, WHO 2002). Several decades later, other international agencies[21] began promoting various models of “development with identity” which emphasized community participation, cultural sensitivity, and respect as necessary for indigenous health (Aizenberg 2014)}(Jacklin Wayne 2004, Flores Martos 2011).

Official recognition of ethnomedicines is a particularly tangible way in which states embrace indigeneity, also using them as heavily politicized tools to achieve state agendas (Jordan 1997, Kumar 1997, Ferzacca 2003, Broom, Doron et al. 2009). For newly independent nations, “traditional” medical systems help establish a unique identity distinct from neighboring states and the colonial legacies of biomedicine (Leslie 1969, Bastien 1992, Ferzacca 2003), and foster national pride in the face of globalized capitalism (Farquhar 1994, Lee 1997). In India, institutional medical pluralism of several ethnomedicines was used to alleviate inter-ethnic conflict (Kumar 1997). In Cuba and China, states employed traditional medicines to cost-effectively extended access to primary healthcare, serving to legitimize Communist regimes (Brotherton 2012, Basilico, Weigel et al. 2013)}(Lee 1997).

Indigenous medical systems are well-suited to identity work as the nature of “tradition” can be easily molded to rhetorics of cultural authenticity or ingenuity. As Ferzacca shows, medical systems in Indonesia seen as “hybrids” were rejected, while “traditional” Javanese systems were equated with values of self-control that benefited the nationalist project (2003). Through medical revivalism, “traditional” medicines modernize in response to biomedical technology, maintaining both cultural distinction and acceptance by state agencies (Leslie 1969). In Cuba, this process was driven by the state, which “rediscovered” and “modernized” natural medicines to mask

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[21] Notably the Inter-American Development Bank, World Bank, PAHO, and CARE International

deterioration of communist medical infrastructure (Brotherton 2012). Likewise, traditional medicines and beliefs can be used to justify uneven distribution of biomedical resources in indigenous communities, citing "cultural preference" for care methods that conveniently utilize fewer state resources (Kowal 2008, Huayhua 2010).

Indigenous communities and practitioners likewise can benefit from state promotion of essentialized versions of indigenous medicines (Comaroff and Comaroff 2009). In the Ecuadorian amazon, ethnotourism (heavily marketed by the state) has encouraged "hypertraditional" shamanic rituals that has provided Kichwa communities a form of cultural survival and a gateway into the global economy(Davidov 2010). In Korea, Oriental Medicine employed nationalist rhetoric to maintain a monopoly over herbal remedies (Cho 2000). However, state recognition can also to lead to forms of cultural appropriation and exploitation that ultimately serve governments more than indigenous peoples (Ferzacca 2003, Browne, Smye et al. 2005). Commodifcation and professionalization can also alienate indigenous peoples from "traditional" health ideologies (Davidov 2010), while also increasing cost and limiting local access to ethnomedicines (Hampshire and Owusu 2013).

In pragmatic terms, traditional practitioners were (and are) viewed as reservoirs of manpower with intimate knowledge of the health needs of the community, providing cost-effective therapies where biomedical treatments may be inaccessible (Akerele 1987, Bastien 1992, Hoff 1997, Basilico, Weigel et al. 2013, Hampshire and Owusu 2013). The "indigeneity" of both ICHWs and traditional practitioners was argued to insure community input and representation (Giblin 1989, Bastien 1992), and facilitate the introduction of new technologies with minimal resistance or disturbance (Bastien 1992, Jordan 1997). However, their participation in such programs often led to loss of community support, as new tensions formed and their “indigenousness” was questioned (Giblin 1989, Bastien 1992), Despite the call for PHC, these health workers are often employed in short-term vertical programs (Pigg 1997, Towghi 2004), ignoring the breadth of ethnomedical healing (Bastien 1992).

State and international pressure to study ethnomedicines force them to be “rationalized” (Lock 1980) and “scientized” under biomedical and neoliberal frameworks (Craig 2011) that label which practices are beneficial, harmless or harmful (Bastien 1990, Jordan 1997, WHO 2002). Training for traditional practitioners has largely focused on “non-reciprocal upgrading” to biomedicine rather than supporting indigenous knowledge or skills (Bastien 1992, Jordan 1997, Pigg 1997, Towghi 2004). The variability and unboundedness of ethnomedicines can also clash with cookie-cutter training programs from international agencies (Pigg 1997). Due to their heterogeneity, traditional medicines are limited in their ability to challenge state interests unless they are able to organize and leverage broad social support (Cho 2000). By building upon nationalist sentiments or rights frameworks indigenous groups can mobilize such support, garnering increased political influence within state structures (Lambert 1997, Boccara 2007).

Institutionalized medical pluralism creates what Lambert calls “hierarchies of legitimacy” (1997), where official ethnomedicines are able to negotiate their own legitimacy with the state but biomedicine retains ultimate dominance (see also Lock 1990, Ferzacca 2003). Systems and practices that are not professionalized may disappear, as patients and practitioners question the authority and qualifications of those who remain as “lay” healers (Kleinman 1981, Farmer, Kim et al. 2013, Hampshire and Owusu 2013). However, greater access to the internet and biomedical technologies have allowed traditional practitioners to adapt practices in more sustainable and competitive ways (Bastien 1982, Kunitz 2000, Hampshire and Owusu 2013). Ferzacca notes the that the state only legitimizes practices that fit into its own ideology, with individuals reinforcing the supremacy of the state through their medical choices (2003). Thus, he argues institutional medical pluralism is a form of governmentality disguised as social welfare, through which the state shapes how individuals and communities may live their lives. For ICHWs and institutionalized practitioners, the negotiation between roles as community advocates and enforcers of the bureaucratic gaze creates conflicting medical citizenships and responsibilities (Bastien 1992, Etowa, Jesty et al. 2011, Nading 2013).

2.4 A New Framework for Affirmative Biopolitics

The primary contribution of this work is a new analytical framework for examening the possibility of an affirmative biopolitics. In doing so, I aim to create a model through which theoretical discussions of an affirmative biopolitics can be applied to widely varying and inherently messy political endeavors in the real world, creating the opportunity for detailed comparative analysis. Similarly, such a framework allows for the comparisons of diverse perspectives and positionings within the context of a single country or policy agenda, as I will demonstrate through the analysis of the following chapters. Drawing on the literature cited above, I identify four components that have been discussed as necessary for the successful implementation of an affirmative biopolitics. By outlining these components, I seek to provide points of comparison through which the frictions of changing biopolitical agendas and mechanisms of control can be examined from diverse perspectives.

I propose that affirmative biopolitics are comprised of four necessary components:

- **Plurality of Lifeways:** where previously marginalized or unrecognized ways of life are incorporated into state constructions of what is considered a good life or citizen.

- **Political and Structural Adjustment:** changes to biopolitical measures and systems of governmentality that shape the evaluation and enforcement of biocitizenship.
- **Networks of Change:** institutions, organizations, and cultural shifts that provide external pressure on the state. These can include changes in expectations of governance, or more direct forms of confrontation with the state.
- **Participatory Governance:** internal mechanisms of change where institutional "outsiders" and/or newly recognized groups are able to directly influence state policy and implementation.

The first component, **Plurality of Lifeways**, is essential to the definition of a biopolitical shift as being "affirmative". It represents an intentional expansion of the definition of biocitizenship where additional ways and forms of life gain biolegitimacy (see also Catherine 2017). It re-defines the boundaries of hegemony, but does not necessarily eliminate processes of exclusion as they are a natural consequence of biopolitics and biopower. It builds upon the theories of politics of recognition, subaltern studies, and biopolitics discussed above.

The second component, **Political and Structural Adjustment**, highlights the necessity of substantive changes in policy, particularly in the forms of standards of evaluation and enforcement that reinforce expanded forms of biocitizenship. Importantly, these political changes must also be supported by changes in institutional structures and policies more broadly that shape how biopolitics are implemented and valued. This political and structural transformation is comprised of layered (and sometimes conflicting) adjustments to existing structures and standards. This process of adjustment is inherently shaped by pre-existing structures and biopolitical agendas that will perpetuate some of the prior forms of inequality. The reality of modern nation-states is dependent upon biopower, and institutions (quite understandably) continue to rely and build upon old systems as they simultaneously attempt to change them. Without these adjustments, any attempt at incorporating plural lifeways is ultimately rhetorical. Likewise, these adjustments provide the fundamental distinction between resistance against biopolitics and an affirmative biopolitics.

The third component, **Networks of Change,** addresses the forces external to the government itself that drive the incorporation of plural lifeways. This is a purposefully broad category inspired by Hardt & Negri's "multitudes" (2005), as well as forms of group-based biopolitical resistance such as biocitizenship "from below" (Petryna 2002) and biosocialities (Rabinow and Rose 2006). It includes fluid networks of cultural influence such as social media, activist organizations, non-governmental institutions (ex. local and international NGOs), and supra-governmental institutions (ex. World Bank and the WHO). These various actors influence one another in complex ways, but those relationships create windows of opportunity for the creation of politics of recognition and the political and structural adjustments necessary to support them. This involves horizontal challenges, where authoritative institutions such as the World Bank exert significant influence over the state through control over funding or policy/initiative design. It also includes challenges "from below" where public critique (or praise) of the state and forms of direct rebellion foment demand for change. The essence of this component is that it creates the expectation for changes to occur, and establishes a degree of accountability.

The fourth component, **Participatory Governance,** addresses internal mechanisms of the state through which those expectations of change are shaped by its citizens, particularly those whose lifeways are newly recognized. This includes "traditional" forms of democratic participation such as voting and petitions, but also more direct relationships of negotiation such as those proposed by Deliberative Democracy (Siisiäinen 2018) and radical Interculturality (see above). While this component can also incentivize the inclusion of plural lifeways, it primarily serves a regulatory function where the adjustments of the state can be influenced by the people they impact, and where they likewise can participate in their enforcement. When this component is seen as ineffective, Networks of Change are likely to be more salient.

I argue all of these components in conjunction are necessary for an affirmative biopolitics to be successfully implemented. It is critical to note that none of these components are themselves sufficient. Likewise, how each of these components are operationalized will vary widely across different contexts and levels of analysis. In addition, incorporating all of the components does not necessarily mean a policy shift should be considered wholly successful, revolutionary, or truly inclusive. As other authors have argued, the ways politics of recognition and biolegitimacy are interpreted, experienced, and enacted are situationally dependent (Alonso González and Vázquez 2015, Grove and Pugh 2015). As Berlant notes, biopower is neither experienced nor employed coherently or homogenously, therefore biopolitical subjectivity varies between ambivalence, acceptance, and resistance (2011). Throughout the upcoming chapters, I will demonstrate how the affirmative biopolitics of *Buen Vivir* and Interculturality are viewed and enacted from the varied perspectives and roles of policy makers, local biomedical professionals, and traditional practitioners.

2.5 Discussion

Throughout this chapter, I have examined the ways in nations define the ideal citizen through biopower and politics of recognition, with health services as an important mechanism for both. Beyond internal politics of the state, these processes are heavily influenced by international networks of colonialism, development, activism, and commerce. I argue that Ecuador's adoption of *Buen Vivir* and Interculturality under the Correa administration represent a shift towards an affirmative biopolitics of life that challenges the biopolitics of previous administrations and models of development. Utilizing the framework detailed above, I examine how Intercultural Health policies operate as a mechanism of biopower within these affirmative biopolitical agendas, and also examine how old and new forms of biocitizenship and biopolitical measures are negotiated from different perspectives of design and implementation. In doing so, I challenge and broaden earlier theoretical perspectives on biopolitics, Politics of recognition, and medical pluralism.

As my analysis of Intercultural Health policies will demonstrate, affirmative biopolitics are an iterative and often self-contradictory process. On one hand, new policies and systems of governance continue to interact with and build upon past structures that supported the exclusion they are meant to counteract. On the other hand, perceptions/experiences of this newfound legitimization of plural lifeways and processes of adjustment vary depending upon who's perspective is taken into account. Finally, there is an inherent tension between the benefits and resources gained through biopolitical acceptance, and the increased surveillance and control such recognition entails.

In addition, my examination of indigenous health policies in Ecuador provides an important opportunity to combine critical insights from historically European theoretical analysis of biopolitics with theories of post-colonial structures of power and indigeneity from Latin America. In doing so, I address how the rapidly increasing importance of population-level governmentality brought on by international development in Latin America is interacting with existing structures of racial and socioeconomic inequalities of power.

Using Intercultural Health policies in Ecuador as a case study, I aim to broaden the application of biopolitical approaches in studies of Politics of recognition and medical pluralism.

While both sets of research have provided significant critical analysis of politics of control, inequities of power, hierarchies of legitimacy, and the impacts of standard-setting and data evaluation; they tend to avoid discussions of biopolitics, preferring discussions of policy impact and governmentality more broadly. This is perhaps due to the conflation of biopolitics with neoliberal governance, or perhaps with the ways many discussions of biopolitics have tended to ignore and even negate the possibility of a meaningful politics of recognition in the governmentality of the state. Despite important contributions, this has meant that situations of resistance against hegemonic standards are equated to resisting biopolitics writ large. In addition, it has limited the potential for understanding the ways in which biopolitics impact policy making and lived experience in other cultural (e.x. non-Western) contexts and models of governance. In uniting these analyses I hope to further discussions of the possibility of an affirmative biopolitics that purposefully seeks to incorporate alterity, including through biopolitics of medical pluralism.

I also argue the historical context of *Buen Vivir* and Interculturality in Ecuador presents a critical case study for the development and critical analysis of theories of affirmative biopolitics through the detailed study of policies in action. Despite a recent surge in proposals of affirmative biopolitics, most of the frameworks surrounding its function are based on philosophical or historical debate (such as the works of Prozorov, Siisianen, Grove, Esposito, Hardt & Negri) that take for granted the dynamic and complex perspectives of policies “on the ground”. As I will show through the varied perspectives of policy makers, biomedical professionals and traditional practitioners, relationships of power and mechanisms of biopolitics are negotiated at many levels of operationalization, with varied intents and means of exerting agency. This approach challenges notions of state biopower as inherently “from above,” or of resistance as exclusively “from below”. I argue that Interculturality, as a form of affirmative biopolitics, is not a complete rejection or defiance of governmentality, but rather an attempt to shape it towards more plural lifeways. The assumption that a truly indigenous state would be completely a-biopolitical is at best naive, and at worst racist as it reifies an image of indigenous groups "returning" to a utopic pre-government mode of living. As I detail in the next chapter, the policy proposals of CONAIE and other activists groups, while attempting to subvert traditional colonial forms of governmentality, demonstrate the need to create new but different structures of governance and surveillance.

Furthermore, I explore the messiness of change, highlighting how individuals can enact, experience, and advocate multiple forms of biopower in their everyday lives. Through the proposed framework, I explore the realities and complexities of affirmative biopolitics in practice. As I will show, policy makers, biomedical professionals, and traditional medical practitioners are expected to occupy different roles within the affirmative biopolitics of *Buen Vivir* and Interculturality. With their varied roles and positionality in the four proposed components of affirmative biopolitics, I highlight the complex ways biopolitics can be contested, re-defined, and perpetuated at the same time. In this way, for example we can better understand how Kichwa midwives experience a "cruel optimism"[22] from the failures of radical Interculturality, but at the same time manipulate the systems it created to fight for their version of the Good Life and more inclusive biopolitical measures. Alternatively, we can see the ways in which indigenous and non-indigenous administrators negotiate their roles as government servants limited by bureaucracy and political conflict, with their desires to create meaningful change for the people they serve. In this way, I echo Berlant's critique that biopower "is not lived *a priori* coherently or homogenously"

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[22] This term was introduced by Berlant (2011) to express how that which we desire and hope for can actually threaten or diminish our capacity to achieve a good life. In her book she explores how women experienced the implementation of neoliberal reforms, which promised upward mobility and independence, but instead created a precarious life and ongoing sense of crisis.

(interviewed by Najafi and Serlin 2008), and instead focus on the ambivalence, contradiction and potential of biopolitical subjectivity (Berlant 2011, Lin, Minca et al. 2018). In addition, I argue that the construction and implementation of biopower (and biopolitics) is neither coherent nor homogenous.

In Chapter 3, I explore how the influence of networks of change can create competing definitions of plural lifeways to be include in state policies of Intercultural Birth. In Chapter 4, I analyze how the precarity of biomedical professionals ultimately limits their connections to networks of change. In both Chapters 3 and 4, I address the challenges of biopolitical and structural adjustment in practice. Finally, in Chapter 5, analyze how traditional medicine practitioners and indigenous community members question how plural forms are "included" and what kinds of participatory governance are necessary to create significant change. Throughout all of these chapters, I explore the multi-level negotiation between radical forms of Interculturality intended to upend structures of inequality, pragmatic forms designed to achieve particular outcomes, and cosmetic forms where rhetoric prevails over praxis.

3.0 Chapter 3: Intercultural Health Policy

In this chapter, I introduce Intercultural Health (IH) policies as one of the primary examples of the shift towards an affirmative biopolitics in Ecuador that attempts to legitimize indigenous lifeways and medicines as approved forms of achieving the Good Life. As a form of institutionalized medical pluralism, IH is meant to integrate the biomedical public health system with the traditional and alternative medicines of the populations it serves, both as a way to improve health and to respect patients' individual and collective rights. In particular, I examine the role of national policy makers and activists in establishing new policy standards that codify plural lifeways and participatory governance in healthcare policies. In part one, I contextualize the development of these policies within the history of the Indigenous Rights Movement, international development in health, and state politics. In part two, I demonstrate how Intercultural Health policies are perceived, implemented, and experienced by politicians, MSP administrators, and activists. In particular, I examine the challenges of creating an affirmative biopolitics as they negotiate the inequities of existing biopolitical structures and multiple interpretations of what constitutes a "good life" in the new era of *Buen Vivir*.

3.1 Intercultural Health as Affirmative Biopolitics

In this section, I examine the proposed components of affirmative biopolitics within the historical development of Interculturality as public health policy. First, I outline how overlapping international networks of activists, NGOs, scholars, and health administrators formed the “multitudes” who promoted Interculturality. Next, I review the concrete changes made by the Correa administration to implement the principles of Interculturality in health policies. Echoing the work of other Latin American scholars, I argue they represent a significant transformation toward participatory governance. Likewise, I address the continued unequal power structures and biopolitical controls that stifled more radical reforms within the Ministry of Public Health (MSP).

3.1.1 The Rise of Intercultural Health Policies

Interculturality in health was first proposed by Indigenous organizations (notably CONAIE and Ecuarunari), then taken up by international NGOs, and eventually by state administrators and politicians. The grassroots origins of Intercultural Health, and it's clear adoption by the institutions with the power to implement it, has created real opportunities to challenge long-entrenched ethnocentrism and inequalities in the healthcare system. However (as with Interculturality generally), the diversity of interests among Intercultural Health proponents and entrenched inequalities of power in the public healthcare system have caused significant friction upon its codification and implementation. The historical development of Intercultural Health as public policy is critical to understanding both its promise as an affirmative form of biopolitics as well as the challenges of effecting revolutionary change from the “bottom up”.

During the late 1970s through the 1980s, as the concept of Interculturality coalesced within the movement for Intercultural Bilingual Education, other reforms began to set the stage for similar “revolutionary” changes in healthcare. This post-Alma Alta period shifted international funding and expectations toward health as a human right, with universal access to primary healthcare supported by integration of traditional practitioners (WHO 1978). Inspired by the declaration, Ecuador’s return to democracy in 1979 brought with it a new constitution recognizing the right to health and health care. This was further supported by funding from the MSP and international NGOs to expand primary healthcare through projects training community health workers and traditional medicine practitioners (World Bank 1993). In addition, improved metrics on maternal mortality also shifted attention (and international funding) towards maternal health, as nearly 99% of maternal deaths were in the rural and poor communities of the developing world (Starrs 2006). Perhaps the greatest example is the Safe Motherhood Initiative (started by WHO and WB in 1989) which channeled funding to improved emergency care infrastructure, institutional referrals, and Traditional Birth Attendent (TBA) training (Starrs, 2006). The 500th anniversary of Columbus' arrival in the Americas in 1992, and the first uprisings in Ecuador, also highlighted healthcare disparities for indigenous communities in Latin America. That year, delegates from Canada, Mexico, Ecuador, Peru, and Bolivia requested PAHO focus efforts on indigenous health, stating it was "perhaps the most technically complex and politically difficult health issue of the day" (PAHO, 1992). By 1994, PAHO established the Health of the Indigenous Peoples Initiative of the Americas (known by its Spanish acronym SAPIA) which proposed improving indigenous health through holistic approaches, self-determination, respect/revitalization of indigenous cultures, systematic participation, and reciprocity in relations (PAHO 1993). As noted by the organizers, these principles marked a potential reversal of colonization through the active involvement of indigenous groups in health policy reform (PAHO 1993), and were closely aligned with broader demands of Ecuadorian Indigenous organizations. At that time, the concept of Interculturality remained limited to education, and was not yet applied to the notion of plurinationality nor the discourse of health policy.

Despite the indigenous uprisings and the birth of SAPIA in the early 1990s, few improvements were made to the Ecuadorian healthcare system. In 1993 the MSP attempted (and failed) to establish a National Division of Indigenous Health (DINASI). Insufficient funding and poor management of resources meant the public healthcare system was often understaffed and ineffective (World Bank 1993). The same neoliberal austerity measures that prompted the uprisings required funding reductions, decentralization, privatization, and institution of fee-for-service in the public health system (Tejerina Silva, Soors et al. 2009, Hartmann 2016). This period was marked by "selective primary health care" that funded vertical programs targeting specific health outcomes (De Paepe, Tapia et al. 2012, Hartmann 2016). A key example is the 1994 Ley de Maternidad Gratuita y Atención en la Infancia (LMGAI[23]) , which guaranteed free healthcare only for family planning through postpartum care; as well as to children from birth to 5 years old. But, funding and implementation for LMGAI were severely limited, and were not guaranteed for another decade (Ruiz Chiriboga 2009). Notably, the law was written after consultations with CONAIE, and included reimbursement to accredited traditional medical practitioners for referrals to MSP services. However, no formal accreditation system was established and significant resistance from administrators quelled attempts at TBA reimbursement in the few communities where indigenous organizations and NGOs had established TBA training programs (Gonzalez 2011).

The dysfunctional healthcare system continued to most negatively impact rural and poor indigenous communities, and healthcare reform became a key demand of CONAIE and other activists during the continued uprisings in the late 1990s and early 2000s. Increased participation of women's rights movements provided additional pressure for improvements to sexual and reproductive health (Gonzalez, 2011). Most importantly, international forums organized by NGOs

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[23] [Law for the Provision of Free Maternity and Child Care]

and international agencies (particularly those related to SAPIA) became an important sounding board for activists' appeals to improve access to primary healthcare, eliminate discrimination, and promote Traditional Medicines. Arguably, the first explicit application of Interculturality to health occurred at one such meeting, held in Quito in 1996. As stated by Miguel Lluco[24], then indigenous deputy to the Ecuadorian Congress (PAHO 1997):

> "[In the area of health, we propose to launch a State policy to create a model of intercultural care. I want to emphasize this point. Thus far, the care provided in the dispensaries, hospitals, and clinics has no model- there is no policy and the treatments are from an Occidental perspective]"

The workshop concluded by noting that a major objective was the creation of policies with a focus on Interculturality and gender, particularly those supporting indigenous knowledge, medical practices, and political representation.

Only two years later, CONAIE published its first proposal for a national Intercultural Health policy: the Policy on Intercultural Health and Sexual Rights. It argued for the implementation of a new Intercultural Health system, consisting of clinics in the universal healthcare system that integrate traditional and biomedical services. At these clinics patients could freely choose between disciplines, and providers would have a formal and mutual reference network between health systems (CONAIE 1998). Furthermore, the document demanded structural changes to increase indigenous control in public health, including the establishment of indigenous councils that would guide policy funding, administration, implementation, and evaluation according to each community's needs.

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[24] Lluco was later president of ECUARUNARI, and a founding member of Pachakutik

This pioneering vision of Intercultural Health proposed a radical transformation of the healthcare system, representing part of CONAIE's broader strategy to establish a plurinational state in Ecuador. The policy aimed to reclaim power from state biomedical institutions by dramatically expanding indigenous and community control over health policies. Additionally, the formal incorporation of traditional medical practitioners within the state system was meant to not only recognize indigenous practices, but to also legally reverse policies which had persecuted traditional practitioners and restricted patient choice. Importantly, the proposal recognized the need for indigenous control in data collection and evaluation to support decision making and monitor state progress towards reform. This original version of Intercultural Health clearly aligns with "radical" visions of Interculturality as an affirmative biopolitical project attempting to recognize previously marginalized lifeways through participatory transformations of the state.

Quite rapidly, PAHO and other international organizations began to embrace Interculturality as a political paradigm for healthcare reform. Intercultural Health was deemed critical to overcoming discriminatory practices and unequal access to care that threatened indigenous peoples' right to health (PAHO 2000). PAHO in particular published several white papers and created international partnerships to establish IH policies and programs, largely as part of the SAPIA initiative. It suggested operationalizing Interculturality by: monitoring barriers to accessing healthcare, incorporating intercultural frameworks in health personnel training, promoting indigenous participation in health service design and management, and developing alternative care models that integrate indigenous medicines and beliefs into primary healthcare services (PAHO 2000, PAHO 2002, PAHO 2003, PAHO 2005, PAHO 2006). Notable early policy examples include white papers on incorporating an intercultural focus in the formation of health human resources (1998) and the incorporation of indigenous medicines in primary healthcare (2002). The former demonstrates a clear adoption of the principle of Interculturality as a form of political and societal transformation:

> “The operationalization of the concept of Interculturality supposes the following principles: dialogue founded upon the respect of differences, tolerance of contradictions leading to solidarity, cultural democracy, participation that incorporates representation and consultation, and consensus and convergence towards common objectives.” (PAHO, 1998, p. 18)

On one hand, the rhetoric of PAHO (and other international NGOs such as CARE International) retains the same transformative vision of Intercultural Health as the indigenous activists it was adopted from. It includes the core affirmative biopolitical project of participatory governance that fosters acceptance of plural lifeways. However, the ultimate goal of IH for international agencies diverges from that of indigenous activists in one critical aspect. For groups like CONAIE, IH was part of a broader vision of radical plurinationality, where indigenous communities would share legal control over health administration, evaluation, and finances with the state. In contrast, the models of IH proposed by PAHO and others were ultimately a means to achieve universal healthcare. While they emphasized “representation and consultation” of indigenous groups and incorporation indigenous practices, they largely ignored the demands for challenging national political power structures.

Despite these differences, by the early 2000s international health NGOs became a critical part of the networks of change demanding Interculturality in health and beyond. They provided a direct link between activists (particularly CONAIE and Ecuarunari), NGOs, academics, and high-level administrators (PAHO, 1993c). In addition, they funded numerous IH projects in partnership with indigenous communities throughout the Andes. As discussed in Chapter 1, during the early 2000s multiple streams converged to create a critical policy window for the adoption of

Interculturality and *Buen Vivir* as political paradigms. This is especially true for Intercultural Health policies, with a dramatic proliferation of Interculturality in initiatives and policies across Latin America during that period (see Table 2, (Netsch Lopez 2014)).

Table 2. First Use of "Interculturality" in National Health Policy

Country	Year
Chile	2001
Brazil, Peru, Mexico	2002
Ecuador	2003
Bolivia	2006
Costa Rica, Honduras	2007
Nicaragua	2008
Argentina, Paraguay, Venezuela	2009
Colombia	2011
El Salvador	2014

The "focusing events" that brought attention to the marginalization of indigenous peoples included demands for better healthcare, both in terms of improving access and eliminating neglectful and racist practices. Also, new and better health disparity data from the SAPIA initiative highlighted dramatic health disparities for indigenous populations, which were further underscored with the launch of the Millennium Development Goals. Specifically, Goals 4 and 5 called for a two-thirds reduction of child mortality (under 5 years old) and a three-quarters reduction of maternal mortality by 2015. This created enormous pressure to increase indigenous women's access to and utilization of prenatal and birth care in order to improve countries' overall maternal mortality rate. The pressure to achieve these goals in Ecuador was highlighted by the results of the national ENDEMAIN health survey, which showed that 69% of indigenous women gave birth at home, largely due to distrust of hospitals and preference for home birth and traditional customs (CEPAR 2004).

Furthermore, international networks were coalescing around movements that challenged the superiority and technocratic authority of biomedicine. In 2000, a conference held in Brazil called for the “humanization” of biomedical care, particularly in birth. The movement questioned the technologization of birth and paternalistic authority of physicians, instead reinforcing women’s autonomy and dignity in the birthing process (Page 2001, Umenai, Wagner et al. 2001). Likewise, reports of drastic racial health inequities in the USA and Canada in the early 2000s led to proliferation of models for culturally appropriate care in biomedicine (Saha, Beach et al. 2008, Thackrah and Thompson 2013).[25] These quickly became required components of medical education in the USA, which in turn influenced requirements for international health initiatives funded by NGOs from the United States. In addition, the development of the first WHO Traditional Medicine Strategy in 2002 supported the promotion and integration of traditional medicines in national health policies, an uncommon approach in other forms of culturally appropriate care developed elsewhere (WHO 2002). In this context, programs based on Interculturality provided both a pragmatic and politically cogent strategy for both NGOs and states to improve indicators, particularly in maternal health.

Despite Intercultural Health initiatives and indigenous activism, state reforms in Ecuador at the time were largely symbolic. The 1998 Constitution recognized indigenous rights to traditional medicine and the development of traditional and alternative medicines in national health policy. As such, the MSP established the National Office of the Health of Indigenous Peoples (DNSPI) in 1999, and mandated the promotion, development, and integration of traditional medicines in the new national healthcare policy (MSP 2002). In 2003, DNSPI became the Office

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[25] These models typically required provider education in Cultural Competence (knowledge of diverse medical beliefs and/or the ability to discuss differing beliefs with patients), and Patient Centered Care (holistic care through open communication and collaboration with the patient)Renzaho, A. M. N., P. Romios, C. Crock and A. A. L. Sønderlund (2013). "The effectiveness of cultural competence programs in ethnic minority patient- centered health care—a systematic review of the literature." International Journal for Quality in Health Care **25**..

of Intercultural Health during a major restructuring of the MSP. But once again, none of these advances were backed by concrete strategies or stable funding (Gonzalez 2011, González 2017).

Concurrently, indigenous organizations began to partner with international NGOs such as the Red Cross and the Spanish Agency for International Development Cooperation to improve access to healthcare through models based on Interculturality, including the research site. One notable program is Jambi Huasi, a private clinic in Otavalo founded in 1994 by the Indigenous and Campesino Federation of Imbabura and UNFPA, where patients choose to be seen by biomedical providers (physician, dentist, and obstetrician) or Kichwa providers (midwife, shaman (*yachac)*, and bonesetter (*sobador)*. Another significant program titled HACAP [Humanization and Cultural Adequation of Birth], piloted culturally adapted birthing practices at health centers in 4 provinces through funding provided by Family Care International and USAID.

However, the advances made through these pilot projects remained highly localized and piecemeal despite support from international agencies, indigenous organizations, and the Office of Intercultural Health. By 2005, the MSP had published a handful of policies that encouraged Interculturality, but did little more than define the term (Gonzalez 2011). Intercultural Health in Ecuador still lacked the legal infrastructure and surveillance mechanisms necessary for it to be implemented nation-wide.

3.1.2 Intercultural Health in the Correa Administration

Amid the political upheavals of the early 2000s, progress towards a national policy of Intercultural Health stalled until the election of Rafael Correa in 2007. As discussed in Chapter 1, Correa and Alianza PAIS closely aligned with indigenous organizations and incorporated many of their demands for Interculturality and plurinationality as part of the national political agenda. The sweeping reforms to healthcare resulted in a concerted effort to institutionalize Intercultural Health within the new universal healthcare system. Not only did the 2008 Constitution declare health as a right guaranteed by the state, but also that health services must be Intercultural, and as such must promote and study traditional medicines (Asamblea Nacional 2008). In addition, concrete changes were made to increase the power of indigenous activists and Intercultural approaches within the MSP (González 2017). In 2008, the Office of Intercultural Health was upgraded to a Division of the MSP, and given increased authority through a restructuring of the National Secretariat of Human Resource Development and Remuneration (Gonzalez 2011). With this restructuring, the MSP launched several new pilot projects and intercultural guidelines within the public system. Notably, this institutionalization of Intercultural Health within the MSP was driven by heavy involvement of indigenous organizations (ex. Ecuarunari, FICI, CONAIE), international agencies (ex. CARE International, UNICEF, UNFPA), and directors of existing pilot projects (ex. Jambi Huasi, Cotacachi Midwive's Association) (Gonzalez 2010, Gonzalez 2017).

During the first years of Correa's government, the Division of Intercultural Health built upon the successes of earlier pilot projects by implementing *Parto Culturalmente Adecuado* [Culturally Appropriate Birth] within several MSP hospitals and large health centers. In Otavalo and Loreto existing MSP facilities and protocols were adapted to provide culturally appropriate birth in partnership with indigenous organizations, local midwives, and international NGOs. Unlike previous pilot projects, these Intercultural Birth Centers formally partnered with indigenous midwives associations who took turns manning the centers in order to provide care alongside MSP doctors. The Intercultural Birth Center (est. 2008) at Hospital San Luis in Otavalo, is perhaps the most renowned example of IH in Latin America. There, the MSP, UNICEF, and UNFPA remodeled a portion of the hospital into an intercultural birthing suite including wooden walls, a hearth for preparing herbal medicines, ropes and bars for vertical birthing, as well as locally woven wraps and *chumpis*[26] used for birth and post-partum care. A group of 13 midwives rotated in 48 hour shifts at the hospital, so patients could choose to be seen by a midwife or doctor no matter the time of day. The program won several international awards, and was considered a major contributing factor to the near elimination of maternal deaths in the health district (UNFPA 2011).

The policies of Correa's first presidential term contain a notable shift from merely stating services *should* be intercultural, to clearly outlining procedures and strategies to operationalize Intercultural Health. In particular, the 2008 Plan for the Accelerated Reduction of Maternal and Neonatal Death calls for *intercambios de conocimientos* [knowledge exchanges] between MSP doctors and local midwives, and defining roles for referral and integration of midwives with local health centers. In 2009, the Technical Guide for Culturally Adequate Birth Care[27] (what I will refer to as the PCA Guide) was created with the extensive participation of "networks of change" advocating for Intercultural Health, and was meant to create national standards of practice based on experiences from Otavalo and other pilot projects. The involvement of indigenous organizations pushed the MSP to go beyond technical procedures of vertical birth, to include other adaptations to health center protocols including diet, and family accompaniment (Gonzalez 2010). The plan clearly outlines 15 protocols medical providers must follow to provide intercultural services from pregnancy through post-partum, and includes step-by-step directions of how to manage[28] a birth

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[26] A ˆchumpi is a woven belt of varying widths that is an important part of Kichwa dress. It plays a number of roles for mothers and babies, such as a: support belt for a pregnant belly, a rope to hold onto for birthing in a kneeling position, for tightening a mother's pelvic bones postt-partum, and for a ritual swaddling of a newborn, known as *maytu.*

[27] *Guía Técnica De Atención Del Parto Culturalmente Adecuado*

[28] A note on terminology: when discussing birth, an important distinction is drawn in Spanish between *atender* a un parto [to provide medical assistance during a birth], and *asistir / acompañar a un parto* [to be present at a birth / to be a companion to a birthing mother]. This difference is critical to debates over medical authority and value in intercultural settings. There are no direct translations in English, so to avoid confusion I will use "to manage a birth" for *atender,* and "to attend a birth" for *asistir* and *acompañar.*

in various positions with the assistance of family members or a midwife. The Guide is the most detailed and explicit policy for operationalizing Intercultural Health in Ecuador, and continued to be the standard of practice at the time of research.

By 2011, the adoption of intercultural discourse in Ecuadorian health policies had largely been limited to sexual and reproductive health. However, as the Correa administration continued to operationalize its Plan of *Buen Vivir*, the expansion of the universal healthcare system included a broader application of Intercultural Health. The guiding policy, the Model for Comprehensive National Healthcare Focused on Family, Community, and Interculturality (MAIS-FICI) published in 2011, outlines several strategies for operationalizing Interculturality within local health systems, including regular involvement of traditional practitioners as members of local health committees, and as collaborators for identifying families in needs/at risk. The local health committees are meant to help clinic administrators tailor services to the community's needs and cosmovision. In addition, the MAIS-ICI established the new position of Primary Health Technicians (TAPS), community health workers selected from within the community who serve as a cultural bridge and logistical guide between clinic staff and community members.

This increased institutionalization of IH in national health policies was also supported by international NGOs and regional health consortiums. In 2008, PAHO published "A Vision of Intercultural Health for Indigenous Peoples," promoting IH as a means to achieve the MDGs (PAHO 2008). The same year, the Andean Health Organization approved the "Andean Plan for Intercultural Health," designed to promote and monitor IH programs and policies in Bolivia, Chile, Colombia, Ecuador, Peru and Venezuela (ORASCONHU 2008). In 2009, PAHO proposed the creation of a system to acredidate intercultural health services (PAHO et al., 2009), and in 2011 UNFPA published 23 standards for intercultural maternal health services in hospitals and clinics

(UNFPA, 2011). These white papers further signaled an important shift towards operationalizing IH through specific and monitorable actions. These shifts were reinforced in Ecuador by the 2013 Plan for *Buen Vivir*, which outlines state strategies for achieving Interculturality in Health, including the creation of IH training for MSP personnel, establishment of investigatory and intellectual property protections of traditional medicines, and mechanisms of community based evaluation, and generating mechanisms for the "progressive incorporation of traditional and ancestral health agents in the public healthcare system." As will become clear throughout this chapter, however, these advances in policy agendas were broad, leaving the challenging details of creating new standards and biopolitical paradigms to the MSP.

From 2011 through 2016 few new policies specific to Intercultural Health were published. However, several new initiatives were implemented nation-wide. From approximately 2011-2013 hundreds of Intercultural Health Technicians were hired by district health offices to create a national registry of traditional and alternative health providers. This position was phased out with the start of the TAPS program (see Chapter 4). In addition, local health centers were required to work with community members to maintain medicinal gardens, part of national policy that was being written as research was being conducted. The Sub-Office of Intercultural Health has also held events to promote traditional medicines, including publishing a book detailing the lives of 30 traditional medicine practitioners throughout the country (MSP 2016). During this period, the PCA Guide was scaled up as part of efforts to increase maternal health care at local health centers through the implementation of *Parto en Libre Posición con Pertinencia Intercultural* [Free Position Birth with Intercultural Pertinence] (what I refer to as PLPPI). As part of this effort, the national protocols for birth care were redefined to align with practices common to both humanized birth and indigenous midwifery[29]. By early 2016, over 70 health centers and hospitals throughout the country were equipped with PLPPI rooms.

These initiatives were evaluated and reinforced by new measures and standards of practice created outside of the IH office (although with its input). This includes new accreditation requirements for MSP establishments. Discussed in more detail in Chapter 4, these requirements for clinics included structures of community/traditional practitioner participation in surveillance of priority populations, ethnically segregated patient and staff data, and implementation of PLPPI in certain regions. Likewise, the international hospital accreditation standard of Baby Friendly Hospitals (and initiative of UNICEF and the WHO) was adapted to include PLPPI as part of the requirements, relabeled in Ecuador as Mother and Baby Friendly Health Establishments, or ESAMyN (MSP 2015). This formed part of the TSSE reforms that prioritized international accreditation of all MSP hospitals. The initiative was launched in 2015, but had not yet been implemented at the time of research.

As this research was being conducted in 2015-2016, the Sub-Office of Intercultural Health was creating a policy for medicinal plant gardens at health centers, and finalizing a national Manual for the Articulation of the Practices and Knowledge of Ancestral Midwives in the National Health System (I will refer to this as APKAM Manual)(MSP 2016). The final policy outlines a process that certifies traditional midwives so they can not only attend, but actively manage births within MSP institutions containing PLPPI rooms. In this case, the midwife is assisted by the MSP doctor who only takes over in the case of complications.

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[29] These include banning the Kristeller Maneuver, limiting vaginal dilation checks, and episiotomies; encouraging skin-to-skin contact and breastfeeding immediately after birth, and delayed cord clamping.

The APKAM Manual outlines a dual-certification process by which midwives are first identified by the community and voted as meeting minimal standards of experience, ethical practice, and good standing in the community. Then, midwives are trained in hygiene and obstetrical complications and management by the MSP and must pass an oral exam to obtain the final certification, valid for 5 years. In addition, local health centers are required to host regular "knowledge dialogues" between biomedical staff and certified midwives, to train each other in different methods, and guarantees the Intellectual Property Rights of traditional practices/knowledge. Finally, it establishes requirements and documentation for referrals and counter-referrals between midwives and MSP providers. Certified midwives must refer patients to the MSP for prenatal, birth, and postpartum care; and MSP providers must counter-refer all of those patients back to the midwives. If/when certified midwives do manage a birth at a health center, any remuneration for the midwife is to be negotiated directly with the patient.

As the national policies for Intercultural Health have evolved, so too has the definition of Interculturality. The early national policies referred to Interculturality as simply "mutual and equal dialogue between distinct groups that benefits all" (GONZALES 2010). While the 2008 Technical Guide for Culturally Appropriate Birth also mentions this dialogue, it specifies the purpose as the "construction and fulfillment of agreements" through the "institutionalization of Interculturality by the government in ways that are applicable" (MSP 2008)p. 28. Much like the Interculturality employed by NGOs, the state usage here eschews the radical plurinationality of the indigenous movement. However, it further recognizes (and puts into action) the need to alter state institutions and forms of governmentality as a critical component of "questioning the social and cultural model that tends to exclude other knowledge/traditions in health" (MSP 2008)p. 28.

Later policies, such as MAIS-FICI define an intercultural dialogue "founded on the recognition of the other without barriers or social hierarchies" in which the State, mestizos and ethnic groups can "debate the provision of comprehensive services appropriate to their cosmovision; or that at least values it, respects each system, and guarantees access through choices based on an equal footing" (MSP 2011)p. 45). The APKAM Manual contains nearly identical wording, and even refers to the Knowledge Dialogues as a "decolonizing practice" that equalizes the contributions and value of midwifery and biomedicine. Both the APKAM Manual and MAIS-FICI emphasize that such intercultural dialogue allows a collaboration that "respects human and collective rights" (MSP 2011, MSP 2016). Previous policies mentioned the ways in which IH *could* ensure the rights of indigenous peoples, patients, and other marginalized groups. However, these later policies mark an important shift where rights discourses are considered a central component of Interculturality itself. While this could represent a realignment of Interculturality back towards the demands of activists, I discuss the deeper political conflicts it represents in the following section.

It is clear the Correa administration made concrete and significant strides in incorporating Interculturality within the national health system (Gonzalez 2011, Gallegos, Watersb et al. 2017, González 2017). In Bolivia and Peru, Intercultural Health has often been critiqued as a superficial bandaid, meant to make severely underfunded and insufficient health services seem more appealing (Fernandez-Juárez 2010, Pesantes Villa 2014, Guerra-Reyes 2019). In Ecuador, however, the institutionalization of IH was part of the much broader socialist reforms of *Buen Vivir* that greatly expanded access to primary healthcare. Nevertheless, its implementation has often been problematic and not without critique.

For one, the number and reach of Intercultural Health policies is limited, and almost exclusively applied to sexual and reproductive health (Maldonado-Bouchard, Bouchard et al. 2015, Gallegos, Watersb et al. 2017, González 2017). The policies have largely only been implemented in regions with majority indigenous populations, and several were still considered optional guidelines at the time of research (Gonzalez 2011). As others have noted, the efforts to scale-up the personnel and physical infrastructure of the new healthcare system were considered higher priority than following IH recommendations, particularly provider training in Interculturality or culturally adequate birth (Quinaluisa and Rosero 2016, Arévalo Gross 2017, Llamas and Mayhew 2018).

Perhaps the most contentious conflict is over what "integration" of the public healthcare system and traditional medicines should look like, both in terms of professional responsibility and pay (Gallegos, Watersb et al. 2017, Llamas and Mayhew 2018). The famous midwife-MSP partnership in Otavalo, for example, dissolved in 2012 when external funding[30] to remunerate the midwives for their rotations in the hospital ended. Citing legal restrictions, the MSP refused to pay remunerations and instead hired an indigenous health technician to work in the Intercultural suite during regular clinic hours. In addition, activists and indigenous practitioners have expressed concerns about the appropriation of both Interculturality and traditional practices by the state (González 2017). In the following section, I use the voices of MSP administrators, legislators, and activists to examine how these issues are both created by and negotiated within the bureaucracy and biopolitics of the national health system.

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[30] Provided by funds from UNFPA, and later the municipal government.

3.2 Enacting Intercultural Health Policy

By the time research began in 2015, Intercultural Health policies had been constitutionally mandated in Ecuador for 7 years- enough time for critical reflection on the outcomes of both the indigenous uprising and the self-proclaimed “revolutionary” Correa government. For both MSP and activists, Interculturality was still seen as an important normative principle guiding the work to be done to improve the health of the country. The passage of time, however, has not clarified discussions of Interculturality or how it should be implemented. As discussed in Section 1, the implementation and development of new IH policies overlaps significantly with discourses and policy trends towards humanized/patient-centered care, indigenous rights, and health-related rights. In the following subsections I demonstrate how these themes merge in the ways national policy makers, MSP administrators, and activists construct Intercultural Health as an affirmative biopolitics.

Central to my argument, I address how national level policy discourses, views on implementation, and the subjective experiences of Intercultural Health policy creators fits within the affirmative biopolitics of Interculturality and *Buen Vivir* generally. First, I examine how interlocutors' discourses of Intercultural Health framed it as a mechanism for improving lives, recognizing alternative lifeways, and challenging social inequities within biomedicine. Second, I discuss their views on how IH is implemented and evaluated, and what this means for its role as a biopolitical endeavor, rather than simply political rhetoric. Third, I discuss the personal reflections of these policy creators and activists as they negotiate conflicting goals and worldviews. Throughout these sections, I identify two important axes of negotiation or friction around the affirmative biopolitics of Intercultural Health. First, is a debate over which fundamental rights Interculturality in health is meant to strengthen: the right to medical autonomy, or the right to cultural difference. Second, is the conflict over the impact of "biopoliticizing" traditional medicines: Is it a method of control and cultural erasure? Or is it a way to concretize the importance of traditional medicines to the nation?

3.2.1 Discourses of Intercultural Health Policy

Much like the scholarly debates over Interculturality and *Buen Vivir*, the discourses of Interculturality I encountered in the field were remarkably similar when it came to the definition of the core normative principle. Nearly everyone interviewed agreed the basic tenet of Interculturality consisted of mutual respect and dialogue between culturally distinct groups:

> "In essence, Interculturality is the respect one has towards the knowledge of another person. Respecting, understanding and accepting those knowledges that a person who is very different from me may have. And within that respect, finding a point of reflection in which we can have a dialogue." - Dr. Juan, MSP IH Policy Writer

> "For me it's clear, Intercultural Health is the respect that should exist as much between Western medicine and ancestral medicines, not just indigenous medicines but afro-ecuadorian, montubio, all of them. That they're at the same level, neither is better than the other. That there is a mutual respect, a coordination, a permanent dialogue between the two when the pathologies of a patient requires." -Darwin Tamba, Jambi Huasi Administrator/ Indigenous Rights Activist

Overall, interviewees felt Interculturality in health compelled the inclusion of previously marginalized groups and ways of living into the mainstream healthcare system, particularly through birthing policies and relationships with midwives and other traditional practitioners. This description was so frequent it often felt as though there was a singular textbook definition of Interculturality that permeated policymaking spheres. This was particularly true of MSP administrators, with several beginning public talks with a quoted definition of Interculturality (often from the Guide for Culturally Appropriate Birth). Understandably, for health professionals and policy makers the discourse of Interculturality generally was firmly rooted in the rhetoric already established in formal policies and laws.

While this could be interpreted as simple parroting of expected political rhetoric, all interviewees described intercultural health as a mechanism for challenging problematic hierarchies within biomedicine. For them, the primary role of intercultural dialogue is to foster meaningful coordination between traditional and bio-medicines in order improve care. Notably, they all recognized that such interactions necessitated challenging the supremacy of biomedicine in the public health system. Dr. Cynthia, the Director of Intercultural Health for the MSP Zone 2 (where the research site is located) notes this means upending the historically ethnocentric approach of biomedicine:

> "This is one of the biggest challenges of Intercultural Health, that the professionals adapt to a different way of life, that they accept the culture of our population and their beliefs. Because they have lived their entire lives that way. We basically came to throw out their cosmovision and way of life. It's practically part of us that this population changes its cultural practices."

Dr. Juan, one of the authors of the forthcoming APKAM Manual, details how this is achieved:

> "What we're striving for is that as much the doctors as the midwife initiates a dialogue. So if the health professional is going to give a talk about warning signs during birth- that they do it, but also that the midwife contributes from her ancestral knowledge about what signs they look for. So that there's this harmony and this dialogue that breaks this hegemonization that has always existed from the health personnel. That 'I'm the one who teaches and you're the ones who learn', but no. We are looking for a methodology in which the dialogue is circular, so the health professional strips themselves of their lab coat."- Dr. Juan, MSP IH Policy Writer

For nearly all interviewees this intercultural dialogue not only meant recognition of difference, but was also seen as a primary mechanism for challenging the dominance of biomedical practices and mestizo cultural norms in the public healthcare system. In this way, the general discourse of Intercultural Health reflected that of more "radical" forms of Interculturality espoused by

Indigenous activists, who view it as a method of decolonizing state institutions through incorporation of indigenous beliefs and practices.

In addition, interviewees felt that an intercultural approach decreases other forms of discrimination that had been deeply entrenched in biomedical practice. Many discussed the tendency to treat patients as "numbers" rather than individuals, with doctors often ignoring the socioeconomic circumstances that influence their patients' health. This was particularly true for discussions of birth, with activists and MSP administrators alike acknowledging widespread mistreatment of laboring women via invasive practices, verbal abuse, and disregard for comfort and privacy. They all recognized a significant part of the challenge was the outdated training at medical schools which lagged behind policies calling for training in patient centered care, humanization of services, Interculturality, respect of patients' rights:

> "We considered it normal before to have a woman lay down and wait, haver her push, separate her legs and we just sit there waiting until the child is born. But obviously we weren't putting ourselves in the woman's place. [Laughing] one time we even had a [male] doctor lay down on the gynecological table and had him open his legs and told him to push there by himself! The health professionals realized how difficult it is to give birth that way. So we decided that women should be able to birth how they wanted to, because we were violating their rights. That's how the idea of free position birth was born." -Dr. Gabriella, Zonal IH Coordinator

Activists and administrators agreed that improving the treatment of patients required a dramatic change within the biomedical system. As one Parto Es Nuestro activist noted, this mistreatment is a form of "structural violence, fully cemented within our society and medical system". Dr. Juan, a policy writer for the IH Sub-Office likened the problem to processing chips. In his view, doctors leave medical school with pre-programmed chips that make it incredibly difficult to challenge the practices they were indoctrinated with. By including Interculturality within the curriculum, those harmful practices could be questioned and a new generation of practitioners with improved "chips" would be created.

All interviewees were keenly aware that ethnocentrism and racial discrimination were important factors in biomedical malpractice and negative experiences of the healthcare system. For them, Intercultural Health policies not only directly addressed these issues, but were also emblematic of the shift within the government towards inclusive and respectful healthcare:

> "I'll be honest, we're still contending with the matter of trying to convince people the health system has changed, that it's changed for the better. But this bad reputation that was created many years ago is really hard to break. That was the point of implementing free position birth. That women go to the health services, that they receive care with quality and warmth, more than anything respecting the culture that they have." -Dr. Gabriella, Zone 1 IH Administrator

> "We're all citizens. we're all interacting interculturally. Its not that, 'oh she's Kichwa she'll give birth sitting', and 'oh she's colono she'll give birth in the lithotic position', or we'll do a c-section. We're all people, we're all governed by the same constitution. We're all sheltered by this, our beautiful and diverse Ecuador."- Dr. Martina, Zone 2 IH Administrator

Thus, IH policies are viewed as the government's attempt to right the wrongs of the past where biomedical supremacy and ethnocentric discrimination fueled mistreatment of patients and cultural erasure. In doing so, it is meant to overturn previous medical and social hierarchies that validated only biomedical and white/mestizo health practices. In this way, Intercultural Health is understood as an affirmative political project that recognizes multiple forms of medicine (and birth) as legitimate.

Importantly, several administrators also highlighted the grassroots history of Intercultural Health, and the impetus created by the networks of change discussed above. Although they were part of the governmental bureaucracy tasked with implementing IH policy, they acknowledged those policies exist because of the demands of the public:

> "It's a policy with a lot of history, it didn't start with the technical guide for culturally adequate birth. It's an historical achievement and a historical fight of the pueblos and nationalities, for more than 30 years. It's a big challenge and we have to keep fighting little by little to achieve it."- Dr. Juan, MSP IH Policy Writer

> "It's a big process of change and adaptation, especially for the health professionals. But not really for the patients, because they were already asking for those options"- Dr. Martina, Zonal IH Director

For both Dr. Juan and Dr. Martina, Intercultural Health policies were not simply an effort by the MSP to change itself out of its own goodwill. They are rooted in the people marginalized by state, desires not included within instutions.

While interviews and public events reified the affirmational goals of Interculturality as a politics of recognition, they also underscored its importance as a biopolitical mechanism for evaluating and improving the health of the nation. On the one hand, Interculturality in health was deemed necessary because of staggering gaps in health between indigenous/mestizo and rural/urban populations. Nearly all discussions included subtle references to the 2004 ENDEMAIN survey that showed low rates of prenatal care and institutional births, and higher rates of maternal mortality among indigenous women. In addition to all of my interviews, every public talk I attended on Intercultural Health featured campaigns to lower rates of unnecessary cesarean sections and Maternal Mortality. The former was of particular concern to birth activists, who saw the recent media storm on high c-section rates as a window of opportunity to raise awareness amongst the public and politicians about obstetric violence. As one birth activist told me,

> "Almost all of us were told we needed a c-section for one reason or another, but now we know it doesn't have to be like that. The WHO says there's no reason it should be that high, so we came here [to the Humanized Birth Policy Forum] to demand our rights" Suzana, El Parto Es Nuestro Member

In this way, statistical measures of birth and health, especially when stratified by ethnicity, were framed as a call to action to incorporate an intercultural approach to healthcare.

On the other hand, those same metrics were also seen as important evidence for the success of intercultural approaches in health. In these discussions, the success of Intercultural Health was often defined by quantifiable statistical changes including increases in prenatal checkups and institutional births, as well as reductions of emergency c-sections and maternal and neonatal mortality rates. Several of the MSP administrators and birth activists, for example, noted how TBA programs in other countries led to a decrease in maternal mortality rates. They also emphasized how recent biomedical research has shown the advantages of intercultural birthing practices for the health of the mother and baby, including allowing birth companions, vertical birthing positions, consumption of food and beverages during labor, and the use of massage and physical support. MSP administrators in particular supported the expansion of PLPPI rooms throughout the country due to their potential to reduce costs[31] and redistribute high patient loads from regional hospitals to local clinics. A clear example of this biopolitical justification for IH policies comes from Dr. Martina, the IH director for Zone 2, where the research site is located:

> "What we want in PLPPI clinics is to kind of translate that experience of home birth to something very similar, but with specialized care. Especially in these health centers, we've already improved the elimination of episiotomy and tearing, And above all managing birth in clinics with free position birth decongests the hospitals."- Dr. Martina

Because of this heavy emphasis on statistical improvements to health, it was clear that for MSP administrators the intrinsic value of IH policies was its potential to shift health indicators towards the goals set by the Plan for *Buen Vivir* and the World Health Organization. While they also cited improved patient satisfaction as another goal, it was in terms of improved satisfaction rates**.** However, indigenous and birth activists also utilized these rates of inequality and improvement to strategically justify their particular vision of what IH policies should be and achieve. As will be demonstrated throughout the remaining sections, the statistics deemed most important to the

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[31] Even when complications and level of risk are controlled for, Cesarean Sections are often 30-50% more expensive than vaginal births due to surgical interventions (requiring more expensive specialists) and longer inpatient recovery (Howell et al 2014; Piovezan et al 2019).

biopolitics of *Buen Vivir* highlight significant divisions within discourses and methods of implementing Intercultural Health policy.

3.2.1.1 Conflicting Affirmative Biopolitics of Birth

So far, I have argued that MSP administrators and indigenous and birth activists employ a similar definition of Interculturality, and recognize it as a necessary strategy for improving health disparities. They agree that IH policies entail dramatically changing the existing national health system in order to combat inherent forms of discrimination and mistreatment of patients along ethnic and professional lines. However, the discourses of Intercultural Health policy diverge when it comes to what rights it is meant to achieve. This comes as a natural consequence of the multiple actors involved in the formation and institutionalization of Interculturality in health, each with their own ideological bent and ultimate goal(s) for the policy they endorse. These divisions are most clearly seen in discourses of intercultural policies on birth and traditional midwifery, which were the most well-known and widely implemented at the time of research. As discussed in Section 1, the creation of IH policy has always been heavily influenced by indigenous organizations, humanized birth advocates, and international agencies striving to improve health indicators. The overlapping interests and advocacy of these groups were critical to the realization of Intercultural Health as actionable policy. In essence, they were the "multitude" that pushed Interculturality from a radical political platform of the indigenous movement to an affirmative biopolitics of the state.

However, the varied agendas of these groups persist, and tug at the central ideology of Interculturality in health. As I will show in this section, the core meaning and goal of Intercultural Health is still under debate. At a bird's eye view, the debate could be understood as prioritizing health outcomes versus prioritizing the promotion and integration of traditional medicines and practitioners. While this is an important point of negotiation, particularly in terms of deciding how to implement and measure IH policies, it is not so clear-cut in the ways national policy creators and influencers talk about the purpose of Interculturality as a guiding principle of healthcare.

In both written policy and discourse, administrators and activists alike recognized that significant improvements in health disparities could not be achieved without culturally appropriate health services involving traditional practices and vice-versa. Rather than a pure dichotomy, everyone employed varying degrees of both discourses. Instead, I discovered the debate revolved around whether or not Interculturality itself was seen as sufficient to create the radical changes required the healthcare system. On one side, are the those who view IH policies as primarily benefitting indigenous populations. In this **Reductionist Discourse**, Interculturality is viewed as primarily about a right to cultural difference and that only benefits populations seen as cultural Others. On the other side, are those who employ a **Holistic Discourse** which sees the intercultural process of mutual dialogue and accommodation as broadly applicable regardless of ethnic divisions. In this discourse, the ultimate goal of Interculturality is the right to choice in medical care.

The Reductionist Discourse was largely employed by female mestiza administrators and legislators, while the Holistic Discourse was employed by indigenous activists (regardless of gender) some of whom worked in the MSP. The Holistic Discourse was also used by those with significant firsthand experience with indigenous midwifery, including Dr. Juan a mestizo policy writer for the MSP, Dr. Gabriella- the IH director for the MSP Zone governing the Otavalo Hospital, as well as mestiza and white members of the group El Parto Es Nuestro. The only group of its kind in Ecuador, El Parto Es Nuestro is a humanized birth advocacy group based in Spain with an active chapter in Quito.

The negotiation between these two discourses first became obvious to me through the *Ley de Parto Humanizado* [Humanized Birth Law], proposed in 2016 by the President of the National Assembly, Gabriela Rivadeneira. Citing her own experiences with what she felt were unnecessary c-sections, Rivadeneira proposed a law to require humanized birth practices and restrictions on the use of c-sections and invasive procedures during birth. While the law was never voted on, its lack of Interculturality became a briefly publicized point of contention between Rivadeneira, a leading member of Correa's Alianza PAIS party and Lourdes Tibán, a Kichwa assemblywoman and presidential candidate for the indigenous political party Pachakutik. When Rivadeneira first announced the law, Tibán quickly noted its similarities to her *Ley de Práctica Intercultural para el Parto Acompañado* [Law for the Intercultural Practice for Accompanied Birth] that was shelved by the assembly in 2009:

Gabriela Rivadeneira @GabrielaEsPais 9 Mar 16
En próximos días presentaré Ley de Parto Humanizado; no más violencia obstétrica contra mujeres y recién nacidos. pic.twitter.com/NP9KQxjdnB

Lourdes Tiban
@LourdesTiban

@GabrielaEsPais Sra.Presidenta si de pronto no sabia yo presenté ya en el 2009 la Ley de Parto Humanizado y me archivaron, no es su invento.
10:17 - 11 Mar 2016

[In a few days I will present the Law for Humanized birth; no more obstetric violence against women and newborns]

[Ms. President if you did not already know I presented a Humanized Birth Law in 2009 and they shelved it, it's not your invention.]

Figure 2. Tweets on Humanized Birth Law

Despite Tibán's assertion that she had already attempted to pass a similar law, she drew particular frustration from the differences between the two laws and their initial reception by the Assembly. Both Tibán and El Parto es Nuestro critiqued the new bill for not including Interculturality or existing intercultural birth protocols (cite Comercio and PEN). The earlier bill by Tibán, in comparison, featured traditional birthing practices and the right of midwives to manage births, along with other cultural accomodations included in the Guide for Culturally Appropriate Birth. According to the assembly, Tibán's law was shelved because it duplicated laws already in place, but she questioned why the assembly was so eager to consider this new law that ultimately attempted to change the same issues within the national healthcare system.

Only five days before the public forum in support of the Humanized Birth Law, Tibán and Rivadeneira announced they would unite their bills, which Tibán insisted should be catalogued as "intercultural" (la hora). On May 16 of 2016, I attended the public forum, held at the National Assembly. Up in the gallery with me were several health professionals in white lab coats, but also members of El Parto Es Nuestro. Wearing *polleras* and t-shirts, they held signs saying, "[I gave birth at home with a midwife at 41 weeks with a wrapped umbilical cord]" and "With our midwife mamas for an intercultural birth". Below, on the floor of the assembly were lawmakers, representatives from NGOs and medical organizations, and the Cotacachi Association of Midwives who were prominently located in front of the speakers' podium wearing traditional highland Kichwa dress. In the opening speech, Rivadeneira highlighted the success of intercultural birthing programs in Otavalo, where she was vice-mayor and provincial governor from 2006 through 2011. In her address, she stated:

> "[Our comrades in the MSP are already applying politics of recognition, especially vertical birth, in regions in provinces were we have large indigenous populations who have been isolated from the national health system. But, this humanization should go beyond those protocols, to consider it not just a custom of women of a certain ethnicity, but as an alternative for all women of the country in the moment we decide how to give birth"

With this address, Rivadeneira expresses a subtle distinction between intercultural birth policies and humanization of birth that defines the Reductionist Discourse of Intercultural Health. At the same time that she argues for the expansion of the PCA Guide, she critiques policies of cultural recognition as only for indigenous women. A humanized approach, however, is argued to be more universal, giving **all** women autonomy over their births.

While this may appear to be an overly critical reading of her words, the context of the public forum for Humanized Birth Law underscored this dichotomy of intercultural birth **versus** humanized birth. For one, that quote is her only reference to existing intercultural birth policies throughout the entire forum, while managing to avoid the word "intercultural" entirely. Furthermore, when talking to the members of El Parto Es Nuestro after the event, we all noted the extensive lineup of speakers did not include anyone involved in implementing the PCA Guide, nor any midwives (either TBA or urban), nor Lourdes Tibán. In addition, pamphlets that were handed out only contained the language of Rivadeneira's Humanized Birth Law, with no mention of Tibán's Intercultural Birth bill. Despite their visual prominence in the main gallery, the Association of Cotacachi Midwives had not been invited to the event. As one Parto Es Nuestro member informed me, they had personally contacted the midwives about the event only days before, and the advocacy organization scrambled to gather donations to pay for transportation so the midwives could attend. While is possible Rivadeneira had little knowledge of existing Intercultural Health policies, it is important to note that she served as the vice-mayor and provincial governor of Otavalo from 2006-2011, and was personally involved in the launch of the partnership between the hospital and indigenous midwives.

The events of the Humanized Birth Law forum highlight the conflict between Reductionist and Holistic Discourses of Intercultural Health. For Rivadeneira and other officials who employ the reductionist discourse, Interculturality and Humanization are **distinct** approaches with different target populations, methods of implementation, and sociopolitical impacts. This viewpoint was most clearly expressed at a public colloquia in June 2016 on Intercultural Health in a talk by Paulina Jimenez, then director of the national MSP IH office:

> "One of the challenges I want to highlight is that **with Interculturality what we're trying to implement are politics of difference**. Policies that in some way **are the exception to the rule**, because we know that we don't have a homogenous population, its diverse with many different needs. At times **this has been a trap** that doesn't let us extend the Policy of Maternal Health with Intercultural Focus that allows the **humanization of maternal health for the entire population, because they don't meet certain ethnic requirement**s."

For Jimenez, Rivadeneira and other mestiza administrators I interviewed, the limitation of Intercultural Health policies was precisely its emphasis on culture. While they recognized the need to promote traditional medicines and adapt biomedical services to the needs of local populations, they felt only indigenous women were the beneficiaries of this process. They recognized the importance of a right to cultural difference, but felt it had overshadowed and even limited the right to respectful care they felt was even more fundamental and universal. For them, the most fundamental challenges within biomedicine were the technologization of birth, physician centered care, and obstetric violence. Rather than focus on Interculturality, the use of humanized birth strategies would resolve those issues within biomedicine, for all women.

In the Holistic Discourse of Intercultural Health, however, activists and indigenous administrators/lawmakers felt Interculturality and Humanization were inherently linked. In their view, Interculturality is fundamentally a mutual dialogue to change healthcare according to the patient's and community's needs. This process, then, ensures the humanization of birth where the autonomy of the patient and respect for her needs and experiences are paramount. Likewise, they felt that birth could not be considered humanized if it ignored or violated a patient's beliefs and customs. As María Moreno de los Ríos, member of El Parto Es Nuestro and project coordinator for several international development NGOs, mentioned in her speech at the forum for the Humanized Birth Law:

> “A **humanized birth is the result of a dialogue** between the woman and the person managing her care. It is about respecting her rights over her body and her wishes for how the birth should be managed, what techniques are used. For that reason, **any law for humanized birth must include ancestral medicine**, we **must vindicate the traditional midwives** who have already been providing this care to women in their homes for millennia.”

In a similar vein, Dr. Juan, a mestizo obstetrician (and author of the APKAM Manual), describes how his personal experience of working at an intercultural birth program taught him the importance of humanization:

> “One of the things I learned from [the midwife] was that a pregnant woman isn’t just the moment of birth, she’s everything in itself. And that the moment of birth is a ritual, its a family celebration really. You very much have to **respect what the patient decides in that moment**, what she wants in the process of labor. And **not do anything more than what she permitted**, and to **respect the physiology of birth** respect the power a woman has to give birth.”

In this, and other Parto Es Nuestro events I attended it was clear that humanized birth activists saw indigenous midwifery as both the source and exemplar of humanized birth practices. They discussed birth as a deeply personal and intimate process shaped by culture and personal experiences. Several of the members had given birth at home under the care of urban and indigenous midwives. For these women, indigenous birthing practices and practitioners were not for the exclusive use of indigenous populations, but rather an additional option for all women in choosing their ideal form of birth. In this Holistic Discourse, the ultimate result of interculturally humanized birth is to support a patient’s right to choice and autonomy in their medical care, regardless of the medical system.

This holistic view was also prominent amongst indigenous activists working both within and outside of the MSP. An important example comes from Darwin Tamba, manager of the famous

Jambi Huasi Clinic in Otavalo. He notes at times they have force the biomedical providers to comply with referring patients to the traditional practitioners:

> "They have to comply if they like it or not, because it is our health system. That is how we want to do it, and its for the health of the patient. It's not a whim of ours, it's because of **the right they have to choose who sees them**."

Like the birth activists, Mr. Tamba and other activists I spoke with highlighted that existing intercultural health programs have higher rates of mestizo patients than indigenous. This was the case in Jambi Huasi, were only 30% of the patients were indigenous in a city where over 60% of the population is indigenous (interview with Darwin Tamba). In this holistic discourse of intercultural health both biomedical and indigenous systems are understood as universally valid options for care, necessitating equal status. As Lourdes Tibán noted in her initial response to the Humanized Birth Law, "Intercultural Health should be used to value how different knowledges are equivalent to others to make compatible conditions in public and private healthcare" (Comercio).

For Kuri, a Kichwa activist and policy analyst in the national IH Office, these differing discourses of Interculturality in health stemmed from conflicting interpretations of Interculturality:

> "Many people say that Interculturality is 'treat others how I would want to be treated'. But for me, that's not it, it's the opposite. I want them to be treated how they themselves want to be treated. It's about respecting others, the right to be different."

In this way, Kuri and other activists expressed that Interculturality should not be confused with tolerance of cultural difference. They emphasized all cultures and systems maintain their own inherent value and should be respected on their own terms. For this reason, many felt the Reductionist Discourse common amongst MSP administrators erased the contributions Intercultural Health and indigenous organizations already made towards humanized birth through. As Kuri noted,

> “Human rights are way to make cultural values invisible. First it was indigenous health, then intercultural, then vertical birth, then humanized. They feel the need to modernize an indigenous practice to make people accept it.”

This was certainly part of Lourdes Tibán’s reaction to the proposed birth law, as well as that of the birth activists holding up signs for intercultural birth. In this way, proponents of the Holistic Discourse felt that Interculturality in health was fundamentally about a right to choice, and through it rights of difference and respectful care would also be achieved.

In summary, the discourses of state IH policies (as well as the individuals who influence and create them) acknowledge Interculturality in health as an affirmative biopolitical paradigm. They recognize the need to incorporate indigenous and alternative medical systems as part of the politics of recognition of the state, but also to address discrimination and abuse of patients entrenched within the state healthcare system. While everyone agreed this called for a radical shift within the medical system, they disagreed where and how such dramatic changes should be prioritized. For most mestiza women working within the MSP, including the national director of the IH Office, intercultural health was a necessary but limited approach that only benefits indigenous communities. Through this Reductionist Discourse, they emphasized other overlapping paradigms as more important and universal such as patient centered care, humanized birth, and the rights of women to sexual and reproductive health.

In contrast, those with firsthand experience of traditional medicines- including indigenous policy makers, birth activists, and MSP administrators who had worked directly with indigenous midwives- employed an Holisitic Discourse where Interculturality in health was the primary paradigm by which those advances could be achieved for all Ecuadorians. In turn, they felt the Reductionist Discourse devalued the role of culture and traditional medicines in healthcare and ultimately limited patient choice and autonomy. Everyone justified the need for Intercultural Health to achieve biopolitical objectives of birth (esp. rates of maternal mortality and c-sections), patient satisfaction, and healthcare utilization. In the next section I examine how these conflicts in discourse are heightened in disagreements over the ways in which Intercultural Health should be measured and operationalized as an actionable policy.

3.2.2 Implementing a Biopolitics of Intercultural Health

As an affirmative political paradigm, the discourse of Interculturality spread from the indigenous rights movement into international health development and eventually into the national politics of the Ecuadorian state. Through the previous sections I have discussed how these discourses have varied and involved other overlapping discourses of health. It is clear that the Reductionist Discourse of Interculturality in Health employed more cosmetic and pragmatic forms of Interculturality that ignore (and even undermine) the more radical goals of plurinationality employed in the discourses of intercultural health by indigenous organizations. In contrast, the Holistic Discourse of IH maintains the importance of Interculturality and pushes for more radical forms of integration/recognition between medical systems and structures of power (e.g. community vs the state). In this section, I examine how these differences play out in the process of creating the policy mechanisms that take Interculturality beyond discourse into actionable policy. For my interlocuters this was the most challenging aspect of their role as policy makers and influencers because they recognize that their decisions on what is measured and how it is enforced inherently determine what form of Interculturality is implemented, and in turn has real-world impacts on how traditional medicines are practiced and valued. First, I will examine views on the "data" behind Intercultural Health policies, the standards and statistics used to evaluate and enforce IH policies within the biopolitical agendas of *Buen Vivir*. Then, recognizing the role of biopolitics in shaping citizenship, I examine the structures used to promote participatory governance and a co-responsibility for health.

Policy makers and influencers recognized that even though Intercultural Health policies were meant to change the national healthcare system, they must also fit within its existing biopolitical structures and priorities. The Correa government was clear its construction of the Good Life was defined by achieving the objectives of the MDGs and Plan for *Buen Vivir*. In doing so, the *Buen Vivir* objectives outlined in the 2013 specify that Intercultural Health programs should emphasize maternal and child health (SENPLADES 2013). For this reason, policies regarding culturally appropriate birth and traditional midwifery were heavily prioritized by the IH office:

> "Its a priority of the republic, of the president [Correa]. And, as you well know, an indicator of the progress of a country is the maternal and neonatal mortality rate. So that's why we're so focused on it. But as an office we also want to focus on other things like gardens, and life histories, we don't want to only be focused on that. But yes, at this time it is a priority and we as Intercultural Health want to contribute, and really we contribute a lot"- Dr. Juan, MSP IH Policy Writer

> "For example, midwives do much more than birth,. They cure espanto, mal viento, they cure illnesses with plants, they do massages, they diagnose with guinea pigs. So, it's not intercultural health to only focus on birth and pregnancy. The [MSP] is completely blind in that sense. And that doesn't allow them to make good decisions that could improve ALL the indices of mortality and health."-Darwin Tamba, Manager of Jambi Huasi

For Juan and Darwin, and indigenous policy makers in particular, this limitation of IH to birth was a significant issue. They emphasized that birth policies in themselves do not equate to Interculturality in health. In order to achieve true Interculturality the policies needed to expand to other types of traditional practitioners such as *yachaks* [shamans] and *sobadores* [masseuses/bonesetters], be available outside of indigenous or rural areas, and address forms of medical care and practice beyond physical and chemical treatment, such as spiritual cleansings..

Despite the limited application of Intercultural Health in the broader MSP reforms, the new policies did establish new standards of measurement across the healthcare system. As part of intercultural measures under the Correa Administration, the MSP began requiring the segregation of data by ethnicity and made patient self-identification of ethnicity a standard component of taking medical histories. All interviewees noted this segregation of data in particular has been critical to advancing Interculturality in health policy, as it demonstrates continued gaps in health outcomes, but also evidences the success of intercultural initiatives:

> "We already have statistics, we know which health establishments are providing free position birth and that its not just for indigenous women, but mestiza, afro, or whatever self-identified ethnicity. And with this information we can now generate evidence to say 'look this is how it is' so that even in a very biomedical system the impact is obvious, and little by little they'll offer it more and more"- Dr. Juan, MSP IH Policy Writer.

As expressed by Dr. Juan, for those employing a Holistic Discourse of Interculturality, these data also proved the broad applicability of indigenous birth practices regardless of patient ethnicity.

Table 3. Standards of Free Position Birth with Intercultural Pertinence[32]

Standard	Indicator
1	% of necessary materials and equipment for PLPPI available[33]
2	% of personnel made aware of and trained in PLPPI for management of normal births
3	% of birth plans made during the first prenatal checkup
4	% of births attended by a companion (relationship partner, family member, midwife or other)
5	% of normal births managed in the position chosen by the patient
6	% of normal births following guidelines for vaginal dilation checks (no more than every 4 hours)
7	% of patients satisfied with the care received

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[32] Translated from report matrices provided by the Ministry of Public Health in 2016.

[33] See MSP (2014). Guia de Especificaciones Técnicas para UTPRs Interculturales, Dirección Nacional de Salud Intercultural. for a full list of equipment.

In addition, the PCA Guide as well as the National Plan for the Accelerated Reduction of Maternal Mortality introduced new statistics of birth (see Table 3). Notably, these measures were largely developed through the 2006 HACAP initiative (part of the Quality Assurance Project funded by USAID), and a joint evaluation project by the MSP and UNFPA in 2014 (Arévalo Gross 2017). Although the statistics were recommended by the PCA Guide in 2008, they were not mandatory for all MSP institutions until 2015 as part of the nationwide scale-up of PLPPI. For the MSP administrators I interviewed, the implementation of these standards was critical to the expansion and success of intercultural birth policies. Each health center is required to fill the same standardized data table that is then compiled at the district, zonal, and national levels of the MSP. This centralized data management then allowed the national IH office to monitor and enforce compliance of the standards across the country (see also Chapter 4).

However, the effects of these standards were seen very differently by proponents of Holistic versus Reductionist Interculturality. Paulina Jimenez, the director of the national IH Office expresses this division clearly:

> "Some have critiqued this, saying 'How can you standardize birth rooms? That doesn't take diversity into account'. Perhaps we can mark it down as a new debate about homogenization vs specificity. But at least we can say these birth rooms at least meet the minimum requirement of having 60% of the necessary infrastructure."

On one hand, these standards are a convenient way of measuring compliance that potentially enables a basic universal standard of care. However, those same standards reify the Reductionist Discourse in practice. For proponents of Holistic Interculturality, these standards aided in the appropriation and white-washing of traditional practices that helped create them in the first place.

Although mestiza administrators often referred to PLPPI as a form of "home birth in a hospital," others were quick to point out that the rooms only resemble home birth in very superficial ways. This was reinforced by the primary measurement of the "Interculturality" of

PLPPI as the presence of specific materials and equipment, such as blankets to keep the laboring mother warm and a cord hanging from the ceiling for support during labor. Notably, several of the required PLPPI items, such as exercise balls and birth chairs are not commonly used in indigenous communities. In addition, other actions recommended by the PCA Guide such as offering medicinal teas or massages by the physician or companion are not included within the reported standards. The standards only take into account the role of the physician in birth, and only count midwives in aggregate with other birth companions. Essentially, the standards do not incorporate any measure of coordination with alternative or traditional providers outside of the national healthcare system. While each health center is required to maintain a registry of traditional/alternative care providers, at the time of research there was no method or requirement to report incidental interactions or referrals between systems. The only standardized reporting for these interactions was for MSP training sessions to traditional providers about signs of risk and when to refer community members to MSP health services.

Proponents of the Holisitic discourses noted these protocols and required statistics were inherently NOT intercultural for several reasons. First, they only counted actions initiated by MSP employees who were also the only ones tabulating and reviewing the statistics. In other words, there was little accountability as to the accuracy of the reporting, and little public access to the data that could influence future policy development and implementation. This was particularly important for members of El Parto Es Nuestro, who felt the government and MSP undermined women’s rights to sexual and reproductive health because they do not collect nor publish data on home births or obstetric violence.

Second, the protocols and reporting standards reified a biomedical perspective that did not take into account indigenous or alternative ontologies or practices (discussed in depth in Chapter

5). For example, Kuri, the son of a highland *yachak* was tasked with drafting the new policy on medical gardens in MSP health centers. He was indignant that the regulations only allowed medicinal herbs, saying "the MSP refuses to accept that *alimentación* [food/diet] is medicine". Likewise, Kuri argues the methods of tabulating specific activities to measure Interculturality in practice directly conflicts with indigenous understanding of Interculturality itself:

> "In indigenous communities we don't think like that. Counting certain activities is not how Interculturality works for us."

Dr. Juan, referring to his experiences working alongside indigenous midwives stated,

> "It was very impactful to see a midwife who had to put on all of the medical garb to attend a birth. In essence it really devalued their practices, we tried to turn the midwife into a doctorita[little doctor] and we shouldn't do that."

In addition, they noted that pay for MSP practitioners is justified in numbers of production, or how many patients are seen. However, this was same measure was seen as inappropriate for traditional practitioners as it "de-valued" their approach to medical care. For the protocols to be intercultural, they argued, they must employ traditional practices under their own terms and create measurements of reciprocal relationships.

Third, there were no standards or measurements that equally applied to all medical systems. This is particularly important for activists, as it demonstrated that despite discourses of mutual dialogue and change indigenous medicines remained effectively inferior and subservient to biomedicine in the state healthcare system. Despite resistance to certain biopolitical measures and controls, indigenous and birth activists acknowledged that IH, and the normative principle of Interculturality itself, could not function without surveillance of traditional medicine and practitioners. As Darwin stated:

> “We need intercultural norms, not just occidental norms. If you have a midwife or a yachak working with doctors you need to have intercultural norms that apply to both medicines…We don’t want laws or norms for traditional medicine, we want ones that are applicable to both systems.” -Darwin Tamba, manager of Jambi Huasi Clinic

Essentially, existing IH policies are not intercultural because they reify a separation between the two systems. This separation, in turn, is inherently unequal as it prioritizes the measurement and labor of the biomedical system. Rather than challenging biopolitical controls of traditional medicine entirely, proponents of Holistic Discourse sought new forms of evaluation that could also demonstrate the impact of traditional medicines in achieving biopolitical agendas. Ultimately, proponents of Holistic Discourses of Interculturality critique the biopolitics of IH for not recognizing or valuing traditional medicines as a valid medical system in its own right that contributed to the well-being of the nation.

This conflict over value was especially salient in discussions of indigenous midwives who partnered with the MSP to both develop the PCA Guide and establish the first Intercultural Birth rooms throughout the country- such as the Otavalo hospital and the research site. On paper, these intercultural birth centers allowed patients to choose whether a midwife or doctor would actively manage care. In practice, many of the physicians limited the midwives to supporting roles as birth companions or cleaning staff (discussed further in Chapters 4 & 5). Furthermore, the MSP refused to give midwives monetary remunerations for their hospital/clinic shifts, instead offering birth kits (with sterile gloves, bandages, etc) or community outreach kits (with backpacks, rubber boots, posters of warning signs, etc). This was largely due to legal wording in policies for the national healthcare system, which only allows *técnicos* (similar to an associates’ degree) or higher to be paid as health professionals. All of the MSP administrators I talked with felt powerless over changing these broad legal restrictions, and the national IH office had made several formal attempts to do so. However, there was a noticeable difference in their reactions.

For those employing a Reductionist Discourse of Intercultural Health, the inability of the MSP to pay was simply due to legal and operational limitations that could not be helped. To summarize what several Zonal IH directors told me, "we're in an economic crisis, how can the MSP all of a sudden start paying all 5,000 midwives in the country? And if we only choose a few, how do we decide which ones and make it fair?" Those who employed a Reductionist discourse expressed a frustrated resignation, a "what can you do?" shoulder shrug about the existing structures of the state. Whereas those who employed an Holistic discourse utilized significantly stronger critiques, referring to the refusal to pay remunerations as "labor exploitation," "abuse" and "cultural theft".

They were particularly upset about the Otavalo Hospital, where the MSP hired an indigenous health technician to ostensibly replace the midwives' association that left over pay disputes[34]. As one MSP IH administrator (who on this point wished to remain anonymous) said,

> "Otavalo is a complete farce. But they became so famous for having midwives they needed to have someone… the technician is paid for being a functionary of the state, not for being a traditional medical practitioner."

For them, the state's refusal to remunerate the work of midwives in the national healthcare system, especially given their success in reducing rates of mortality and unnecessary c-sections, was only further evidence that traditional medicine was only valued as a "curiosity" rather than a legitimate health profession. While Reductionist administrators argued physicians trained in Interculturality could provide intercultural medical care to anyone through PLPPI, those with an Holistic mindset argued this could only be considered "culturally adequate" care at best:

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[34] The technician does not consider herself a midwife, nor any specialized traditional medical practitioner, although she higher than average knowledge and experience with traditional remedies and birthing practices (interview 2013).

> "If we want it to be like at home, if we want women to have that kind of care then it's a priority that midwives are in the birth room." -Dr. Gabriella, Zonal IH Director

> "Then the doctors learned how to do vertical birth that was only done before by the midwives, and then you say you don't need them anymore because Dr. So-and-So knows how to do vertical birth. That isn't good, it's a lie, a ruse." -Darwin Tamba, Jambi Huasi Clinic Manager

For them, care could only be considered intercultural if it involved formal inclusion of other medical practitioners, rather than including "preferred" practices based on biomedical criteria. Furthermore, they felt the Reductionist Discourse that expanded access to PLPPI birth rooms also served to justify cultural appropriation by state institutions. Particularly for indigenous and birth activists, they felt the adoption of midwifery practices/labor without institutional respect or remuneration went against the new politics of recognition of the state. Kuri, for example, stated the MSP treated the Otavalo midwives "like they weren't even Ecuadorians," while Darwin argues indigenous organizations should use constitutional protections for indigenous knowledge to sue the MSP for appropriating indigenous medicinal practices[35]. For this reason he felt it was critical to create intercultural norms applicable to both systems, that he felt would further protect traditional practitioners from cultural and labor exploitation by biomedical providers.

However, even amongst proponents of Holistic Discourses, what forms of inclusion were considered appropriate varied in important ways. While many felt integration of traditional practitioners within biomedical institutions was the primary method of achieving Intercultural Health, those working within the national IH office were wary of the effects of such an integration on traditional practices. This was most strongly expressed by Kuri, who in his role as a developer

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[35] In the constitution indigenous peoples are guaranteed the collective right to: "To uphold, protect and develop collective knowledge; their science, technologies and ancestral wisdom; the genetic resources that contain biological diversity and agricultural biodiversity; their medicine and traditional medical practices, with the inclusion of the right to restore, promote, and protect ritual and holy places, as well as plants, animals, minerals and ecosystems in their territories; and knowledge about the resources and properties of fauna and flora. All forms of appropriation of their knowledge, innovations, and practices are forbidden." (Art. 57, No.12).

of IH policies felt that achieving Interculturality through institutional medical pluralism was a fool's errand. As he said,

> "The system doesn't exist to support traditional medicine. It exists to support biomedicine and pharmaceutical industries. The only way to survive as a traditional health provider in this health system is to work in a parallel manner, not be integrated. When you integrate you make one of them lesser."

As noted throughout this chapter, the continued prioritization of biomedicine for achieving the goals of *Buen Vivir* reinforced inequalities of power and authority between traditional and biomedical providers. Although newer policies such as the APKAM Manual and PLPPI standards made attempts to change those inequalities, they did little to change those existing inequalities.

All of the policy makers and influencers I talked with were well aware that their role was to not only create the policy mechanisms to turn Interculturality into a functional health policy, but to also make real the promises of the Correa government to uphold the rights of its citizens' as women, ethnic minorities, and patients. To this point, MSP administrators in particular emphasized the role of policy implementation in establishing a "**co-responsibility for health**". On one hand, this referred to creating structures to teach citizens about the rights to which they were now entitled through the new constitution, and in turn implementing structures through which they can demand those rights (more on this in Chapter 4). For Intercultural Health this included promotional videos and posters stating "you have the right to have a birth companion, you have the right to choose your birth position, you have the right to a humanized birth". Nearly every poster and health form contained phrases such as "its your right, demand it!". To allow citizens to demand these rights, the MSP also implemented obligatory patient satisfaction surveys and complaint boxes in all health centers, hospitals, and administrative offices (see Chapter 4).

In this sense, the MSP was seen as responsible for creating and implementing policies to guarantee citizens' rights, while citizens were responsible for enforcing the systems' compliance with those policies and rights discourses. In a way, MSP administrators measured the success of the birth policies through patients' ability to demand PLPPI services:

> "Intercultural health is a matter of consistency, change won't be seen immediately. It took nearly six years to see that vertical birth was going well. And we've achieved it. If a woman wants to give birth in vertical position nobody will tell her no, because it is a woman's right to demand that we care for her that way"- Dr. Gabriella, Zonal IH Director

Therefore, IH birth policies help foster the participatory citizenship outlined in the Plan for *Buen Vivir* and the Citizens' Revolution. However, it is important to note that the only times I ever saw "demand your rights" phrasing was in reference to *humanized* birth practices. Although most of the MSP administrators I talked with mentioned this aspect of co-responsibility, in practice it largely operationalized a Reductionist Discourse of Intercultural Health that prioritized humanization over Interculturality.

On the other hand, MSP administrators discussed a co-responsibility for health between communities and the MSP to monitor health needs. As several noted, the new healthcare system heavily relied on preventive care. Thus, local clinics relied on community members and traditional practitioners to help identify "at-risk" households, convincing them to seek care through the MSP, and manage barriers to access (ex. transportation, childcare, etc.). For proponents of Reductionist Discourses, this was the primary role of traditional medicine practitioners within the MSP: as points of surveillance and referral from the community to health centers. However, those who employed Holistic Discourses also emphasized the community's role in developing structures of integrating traditional medicine and biomedicine in the national health system. This is particularly true of the APKAM Manual, which outlines a dual process by which both communities and the MSP must certify a midwife so they can actively manage births within MSP institutions. This dual process was seen as validating the empirical knowledge of indigenous midwives as defined by their own communities, and as an effort to ensure the authenticity of traditional practitioners by indigenous communities rather than the state. However, the process also introduces new requirements within indigenous communities over the evaluation of traditional practitioners. While that in itself is not necessarily negative, ultimate approval of midwives is dependent upon their successful completion of the MSP training. Therefore, the ultimate authority for approving midwives remains with the MSP.

Ultimately, the Reductionist vs Holistic forms of Interculturality highlight a division over how Intercultural Health should be operationalized. Through the Reductionist Discourse, this means promoting traditional medicine as a cultural practice (through videos and books) and by incorporating a select number of those practices in rural clinics (ex. Vertical birth and medicinal gardens). However, the priority is to transform biomedical care for everyone through patient centered care "*con calidad y calidez* [of quality and with warmth]," and humanization of practices. For these interlocuters, Interculturality in health means cultural adaptations for ethnic "others" and using traditional medicine practitioners as a community resource to funnel patients to the MSP. For the activists and administrators who employed an Holistic Discourse, Interculturality in health means creating structures where indigenous medicines and biomedicine operate on an equal footing as healthcare professions. However, they recognize this likely will not occur if the MSP "professionalizes" indigenous medicines as has happened in countries such as China and India. Instead, they are attempting to find ways in which both systems can operate in parallel, with financial support from the state but where indigenous communities or organizations retain control. In the next session, I briefly describe the personal experiences of MSP administrators as they attempt to negotiate these conflicts in their roles as IH policy makers.

3.2.3 Subjectivities of IH Policy Makers

As I discussed in the previous section, Intercultural Health policy makers face the difficult task of turning the normative principle of Interculturality, based on mutual dialogue and accommodation, into functional health policy. Despite recognizing the need for radical change in the healthcare system, they cannot simply replace the entire biomedical infrastructure, personnel, nor the institutional and financial apparatuses that already exist to support them. In addition, policy makers must negotiate two divergent perspectives on who Interculturality is for and how it should be measured. Understanding the implications of their work, policy makers deeply felt the challenges they faced in attempting to operationalize an affirmative biopolitics of the state. I believe their discussions of their internal conflicts give voice the multifaceted realities of affirmative biopolitics generally.

First and foremost, MSP IH administrators found themselves bridging two worlds with different visions of Interculturality, each with their own biases towards the value of their respective medicines. Darwin, who has advocated on behalf of indigenous organizations for IH policies stated:

> "We know a yachak should be categorized the same as a PhD, but that is a very high title, you can't put a yachak at that same level. The organizations have to be realistic in what they ask as well." -Darwin Tamba, Jambi Huasi Clinic Manager

However, everyone recognized that the ultimate power and authority lay in biomedical standards and methods. Kuri, himself a proponent of Holistic Interculturality, told me about a particularly contentious meeting with his colleagues in the Intercultural Health Office:

> "I once told them intercultural health is a utopia, and they all agreed. This dialogue of equal to equal doesn't exist. This health system is designed to pasar [move past] other medicines."-Kuri, indigenous activist/MSP administrator

Particularly for those employing an Holistic Discourse of IH, the deeply entrenched structures of biomedical supremacy caused feelings of resignation and cynicism toward their own roles as the architects of Interculturality in health policy:

> "I remember in one situation they said, 'ok give me the files on all the midwives and we can contract one'. But there are 5000 of them, how can pick her and cause all these internal conflicts? These are things in our office that we've talked about internally, that we've discussed, debated. Many people have even cried because you feel impotent, you know?"-Dr. Juan, MSP IH Policy Writer

Regardless of which form of Interculturality was supported, all of the MSP administrators I interviewed referred to their work meetings using terms such as, "debate," "fight," and "argue". As with the quote from Dr. Juan, these descriptions often expressed frustration with the intractability of the biomedical bureaucracy of the national healthcare system.

Particularly for mestizo MSP administrators, they were also employed to show that intercultural dialogue was occurring within the IH office, that indigenous and alternative perspectives were being taken into serious consideration. However, they also highlighted that the ideals of "mutual" and "equal" dialogue are unrealistic or at least naïve. To this point, Kuri argued that ultimately Interculturality did not exist within the MSP. As one of the few indigenous staff members, he resented that his perspective as a Kichwa person was supposed to represent the broad diversity all the indigenous nationalities. If it was meant to be truly intercultural, he argued, they should have staff from each nationality- Cofán, Wao, Montubio, etc.

All of the interviewees felt the slow progress of Intercultural Health reforms was due in large part to the broader bureaucracy of the MSP that limited the power of the national IH Office. Any policy created by the IH office was subject to approval by higher level divisions (such as the *Dirección Nacional de Normatización* [National Bureau of Health Standards] who prioritized indicator-driven national health campaigns, such as the Accelerated Plan to Reduce Maternal

Mortality. They described how the draft of the APKAM Manual was subject to "*una cantidad de peros* [all kinds of objections]" by the higher authorities who "won't make way for change". Despite some notable policy achievements such as the PCA Guide and scale up of PLPPI nationwide, the IH office lacked the power to implement other policy changes necessary for supporting them. This included the absence of intercultural Health curriculums in medical and nursing education programs, as well as required training in vertical birth positions for obstetricians. Furthermore, the IH Office was not given the authority over the executive scope of the policies it created. The 2008 PCA Guide, for example, was optional for district implementation until the scaleup of PLPPI began 6 years later. Likewise, APKAM Manual was shuffled back and forth between being a mandatory regulation and optional guideline. Upon its final approval it was made obligatory only for level 1 health centers (community clinics and health posts), but not hospitals were the majority of women were still giving birth.

In addition, the national IH Office itself had been downgraded several times within the institutional hierarchy of the MSP. Its restructuring as the *Dirección Nacional de Salud Intercultural* [National Bureau of Intercultural Health] in 2008 was notable in that it gave the office transversal authority over much of the MSP (at least on paper). However, in 2013 the office was downgraded to a *Proceso* [Division] under the *Dirección Nacional de Interculturalidad, Derechosy y Parcitipación Social* [National Bureau of Interculturality, Rights and Public Participation]. By 2015, at the Zonal and District levels Intercultural Health were under the control of the *Proceso de Promoción de Salud e Igualdad* [Division of Health Promotion and Equality]. For the MSP generally, this further solidified the implementation of a Reductionist view of Interculturality. As Gonzalez (2017) has noted, this restructuring was meant to broaden the focus of Interculturality beyond indigenous health to a broader rights-based approach. In practice, however, it marginalized the IH office making it subordinate to offices promoting human rights, health promotion, and public participation.

Amongst the MSP administrators I interviewed, this restructuring was viewed with approval by those employing a Reductionist Discourse of IH, while those employing a Holistic Discourse felt it was part of larger processes of political retaliation against the indigenous movement by the Correa government. On this point in particular my interviewees wished to remain anonymous. One MSP employee referred to it as "erasing Intercultural Health off the map," especially after the tenure of Dr. Miriam Conejo (co-founder of Jambi Huasi and well known indigenous activist) as the director of the national IH Office in 2012. Notably, she was and remains the only indigenous director of IH in the MSP. Several interviewees hinted the high turnover in MSP management positions was due in part to suspected disloyalty to the President's party, Alianza PAIS. One MSP employee noted this was one of the primary reasons the MSP refused to negotiate pay with the Otavalo Midwives' Association, as their appeals were supported by an indigenous political party that had split from Alianza PAIS and become an important political opponent. As a clear legacy of the indigenous rights' movement, they felt the IH office in general was viewed with suspicion by party loyalists in high positions of power.

This suspicion of indigenous politics may also explain part of the shift toward a Reductionist Discourse of Interculturality in health. The main proponents of these discourses were mestiza lawmakers and MSP administrators, who cited their own personal experiences of birth and obstetric violence as justification for humanization over Interculturality in birth:

> "I'm answering this as a woman because, obviously when you're a mother and you're giving birth it just feels better standing than laying down. You feel like you have more support standing up with someone rubbing your back and walking next to you. More than respecting culture it's that we go about fulfilling the rights that we have as women." -Gabriella, Zonal IH Director

The birth activists of El Parto Es Nuestro frequently employed strategic references to shared experiences as women in their appeals to policy makers. As mostly white and mestiza upper-class women, they were seen as allies in the fight against obstetric violence. While institutional involvement of indigenous organizations in the MSP waned, the participation of El Parto Es Nuestro was encouraged. For example, the organization was asked to revise the new Clinical Standards for Birth Care in 2015 (obligatory for all MSP personnel) while no indigenous organization was included in the process.

The inherent inequalities of the IH office were especially disheartening for indigenous activists. Darwin and Kuri especially recognized the double-bind of advocating for indigenous rights and values while also having to actively tamper those demands in order to gain any traction with the MSP. As an external activist, Darwin discusses the sense of betrayal this caused:

> "It hurts a lot more when you have an indigenous professional inside of a system, in a public position of power that could do something and they say NO, they tell you the same thing as mestizo people. They had that chance to pave the way for this important step, to convince the authorities- I think its because they're worried about their keeping their positions. So they don't fight for something that is worth it."- Darwin Tamba, Jambi Huasi Clinic Manager

As one of those indigenous professionals, Kuri noted an intense internal struggle over his position within the MSP. He has been asked by other indigenous activists why he continues to work in the IH office despite the lack of meaningful progress. While he often wants to leave, he feels is presence is critical for supporting indigenous medicines in national health policy.

These subjective experiences of IH policy makers and influencers is critical to understanding the full complexity of an affirmative biopolitics. They highlight the challenges of making the idealistic principle of Interculturality real in a system with innate inequalities of power and influence. Most importantly, they challenge the rhetoric of a singular modus-operandi of the state. Rather than a dichotomy of radical external activists challenging cosmetic internal bureaucrats, the situation within the IH Office is more complex. Administrators within the office often found themselves negotiating dual roles as both change-makers and standard-setters. They supported the affirmative rhetoric of inclusion and change in the healthcare system, but recognized that their decisions of how to measure and monitor Interculturality could harm the traditional medicines they aimed to promote. They were wholly aware of their power in the process of Interculturality. If it is a matter of dialogue between distinct groups to create change, they are the ones who decide what is changed and how.

3.3 Discussion

In this chapter I have examined how Intercultural Health policies fit within the broader affirmative biopolitics of *Buen Vivir,* both historically and as a matter of current policy development and implementation. In the first section, I examined how both the discourses and methods of intercultural health policy were developed as part of the indigenous rights movement, and were then disseminated by international health organizations who introduced overlapping discourses of rights based, humanized, and patient-centered care. While this overlap increased the political traction of intercultural health policies, I demonstrate how they have also contributed to a rift within the discourses and policies of Intercultural Health in Section 2. The discourses of policy makers and influencers reified the role of IH as a mechanism of affirmative biopolitics that challenged discriminatory and abusive practices in the national healthcare system. However, they disagreed over whether the ultimate goal of Interculturality was to promote a right to cultural difference or a right to choice in medical care.

By examining the different methods through which IH policies are measured and monitored, I demonstrate the conflict created by these divergent discourses. A Reductionist approach to Interculturality encouraged methods of standardization that could enforce compliance with efforts to guarantee respectful care for all patients. It also fostered a co-responsibility for health where individuals, communities and traditional practitioners played an active role in monitoring community health and the fulfilment of rights through the biomedical healthcare system. In contrast, an Holistic approach sought methods of integrating traditional medical practitioners as valid health professionals in their own right, so patients could choose between medical systems as they see fit. However, they found it difficult to create evaluative measures to monitor and enforce those processes without changing or demeaning indigenous practices and ontologies, largely due to the continued emphasis on biomedical protocols and outcomes. Finally, I use the subjective experiences of policy makers to examine how they interpret their roles as architects within an affirmative biopolitics and how they rationalize their choices in the difficult process of negotiating conflicting discourses of Interculturality.

As I argue in previous chapters, the application of Interculturality into health policy represents an important case study of the reality of affirmative biopolitics. First, all stakeholders of Interculturality in health (indigenous groups, NGOs, MSP administrators, and academics) viewed it as a mechanism to foster a **plurality of lifeways** considered part of the "good life" fostered by the state. In particular this included institutionalizing practices that were once marginalized by the state, including indigenous midwifery and physiologic birth. Second, the push for Interculturality was driven by international **networks of change** that challenged state policy through direct rebellion (ex. the indigenous uprisings), spheres of influence (ex. international development funding), and internal negotiation (ex. IH policy makers). However, these networks also introduced overlapping discourses and standards that have challenged the definition of Interculturality in practice. Third, the implementation of IH policies included shifts towards **participatory governance** of the healthcare system, including consultations with activist organizations for proposed policies, implementation of local health committees, and fostering the ability of patients to demand their rights. Fourth, the realization of Intercultural Health through policy entails a difficult process of **political and structural adjustment** where alternative forms of measurement and surveillance must contend with more exclusionary methods and structures that are still dominant. For policy makers, this included prioritization of traditional practices that could achieve prioritized health indicators, and systems of bureaucratic approval that maintained biomedical authority.

My research echoes the findings of other scholars of culturally appropriate care, institutionalized medical pluralism, and Intercultural Health. As many others have noted, the implementation of Interculturality in health has led to multiple and competing models of Interculturality. In Ecuador, the indigenous rights movement proposed a radical form based on plurinational governance, where indigenous/ethnic organizations comprised part of the institutional health apparatus in order to insure equal access to traditional and biomedicines (González 2017, Llamas and Mayhew 2018). The involvement of international health organizations was critical in launching IH initiatives, but also encouraged an emphasis on health indicators such as rates of Maternal Mortality and Cesarean sections (Llamas and Mayhew 2018, Guerra-Reyes 2019). However, this also encouraged more pragmatic or cosmetic forms of Interculturality that employ intercultural discourse or mild forms of integration that ultimately support biomedical interventions (Ramirez Hita 2009, Llamas and Mayhew 2018, Guerra-Reyes 2019). Others have noted how these forms of reifying a cultural Other create dichotomies where the patients' culture is viewed as a barrier to health, ignore the cultural components of biomedicine, and encourage "fact file" approaches that dilute patient's health ideologies into a fixed set of practices (Menéndez 2006, Boccara 2007, Carpenter-Song, Schwallie et al. 2007, Fernandez-Juárez 2010, Flores Martos 2011). While these critiques are applicable to IH in Ecuador to a degree, I found the situation was more complex. Amongst activists and even within the MSP, policy makers and influencers were aware of and actively attempting to avoid these pitfalls of culturally appropriate care.

As many studies of institutionalized medical pluralism have shown, the process of professionalizing or integrating traditional medicines in the national healthcare system are inherently unequal (Lock and Nichter 2002, Baer 2011). State healthcare systems are necessarily embedded within broader biomedical industries and infrastructures that have considerable more authority and resources in developing and enforcing standards of practice than traditional and alternative medicines (Lock and Nichter 2002, Pigg 2002). This has certainly impacted the creation of IH policies in Ecuador, where the intercultural policies are subject to pre-existing institutional hierarchies that maintain the supremacy of biomedicine. As others have noted, this process of integration is often part of politics of recognition. In my analysis, I have expanded this focus to examine how these politics of recognition entail efforts to change the biopolitics of the state, even though they may be greatly limited by existing inequalities of power.

My analysis of the historical, structural, and personal components of policy creation and implementation also contribute to studies of biopolitics. Many theorists of biopolitics have drawn a sharp dichotomy between the state and its populace. In this construct, the state creates biopolitics that define and control "good" citizens, while the people either conform to or resist against those controls and definitions (Death 2010, Lilja and Vinthagen 2014). While I will examine these issues as well in Chapters 4 and 5, in this chapter I demonstrated how the state itself can be a site of conflicting perspectives and resistance. Furthermore, I address how resistance can entail an embrace rather than rejection of biopolitical control. For proponents of an Holistic Discourse, biopolitics were an essential component to realizing Interculturality as policy. However, they face an uphill battle of challenging existing structures so that new biopolitics of health could be developed in a way that fomented radical Interculturality instead of undermining it.

To this point, the challenges of the IH office can be understood through the lens of biolegitimacy. For the state and policy makers, both biomedicine and traditional medicines are deemed legitimate if they improve health outcomes (or patient satisfaction). However, they are also aware that the existing forms of measuring value risk challenging the cultural authenticity of traditional medicines. This creates a (perhaps inevitable) catch-22, where traditional practitioners demand evaluation/oversight in order to receive equal value as a medical system, but those policies in turn must essentialize or appropriate practices to ensure they can be counted. The risk of this relationship is that it can lead to forms of "ethnogovermentality" that construct a biopolitics of cultural authenticity (Boccara 2007, Bessire 2012). The challenge, then is to attempt to create biopolitical mechanisms that are flexible enough to incorporate lifeways and practices that are distinct and intermixed in complex ways.

Finally, these complexity of policy formation challenges the assumption that indigenous politics are simply a demand for rights based on ones' own ethnicity. It could be argued that Intercultural Health is part of a specialized rights claim by indigenous peoples as a "biologically" distinct group. However, I argue the situation is more complex. The Reductionist Discourse reifies this presumption of IH as a form of biosociality. But the continued persistence of the Holistic

Discourse from both indigenous and mestiza birth activists demonstrates how these initially indigenous demands for change can extend beyond supposed biological membership in the group.

4.0 Chapter 4: Perspectives of Local MSP Services

In this chapter, I examine how biomedical providers interpret and enact those policies in local health services in Napo Province. In contrast to policy makers’ deliberate engagement with Interculturality as a normative principle, biomedical personnel are faced with the practical matters and logistical challenges of operationalizing policies on the ground. As I will show, the reform policies establish local biomedical providers as the foot-soldiers of the monumental shift towards primary health care. In this role, they are in many ways a vanguard of the affirmative biopolitics of *Buen Vivir* in everyday life. As such, their role is to not only actively cultivate the Good Life in their service communities, but also to collect the data used to calculate whether it has been achieved.

In the first section, I briefly address how the politics of *Buen Vivir* and Interculturality have influenced biomedicine as a profession, and the status of operationalizing those policies in Napo Province at the time of research. In the second section, I examine how biomedical practitioners view Interculturality in healthcare and how it relates to (and is often superseded by) the biopolitical targets of *Buen Vivir*. Most importantly, I discuss the frictions between national policy and the realities of operationalizing Intercultural Health and related reforms on the ground with limited resources and professional support. As such, biomedical professionals are often unable and/or unwilling to commit to intercultural approaches despite supporting the overarching goal of accepting plural lifeways and medical practices in healthcare services. Ultimately, this highlights how the challenges of inventing an affirmative biopolitics of Interculturality for policy makers translates into a continued prioritization of traditional biopolitical measures for public healthcare providers.

4.1 Local Health Services and Buen Vivir Reforms

The transformation of the public healthcare system was a fundamental component of President Correa's Citizens' Revolution and achieving the goals of *Buen Vivir*. With relatively high rates of poverty, child malnutrition, and home births, Napo Province was an important site for implementing reforms focused on preventative and primary care. At the time of fieldwork in 2015-2016, the local health network in the cantons of Tena and Archidona was just beginning to show significant progress in operationalizing the national healthcare transformation strategy (TSSE) and national healthcare policy (MAIS-FICI). Like those policies, the healthcare reforms in Napo reflected the affirmative biopolitics of *Buen Vivir* and the Citizens' revolution by increasing access to health services, increasing democratic participation, and incorporating multiple lifeways in biomedical care. In this section, I will outline what specific reforms were taking place at MSP health services in Napo, and general challenges to their implementation.

Many of these reforms were reinforced through measures established in accreditation standards created by the MSP for health centers, called *Servicios de Salud Inclusivos* [Inclusive Health Services] that created reporting requirements for various activities including medical brigades, public outreach, "walking maps" of priority populations, local health committees, and intercultural standards. During research the formal rubrics were still being finalized, and were not publicly available. However, in anticipation of the standards the MSP had begun requiring all health centers to initiate these activities. My interviews with district administrators, biomedical providers, and participant observation in clinic activities provided substantial information about the new expectations of affirmative care in local services.

In the local health district, the goal of increasing access to care closely followed the national health strategies. Existing *puestos* and *subcentros* were given more equipment and staff to extend their services, and several new *puestos* and *subcentros* were opened. At P.S. AMUPAKIN, the biomedical providers doubled from one physician and dentist to two of each during the research period, essentially upgrading it to the status of a *subcentro*. However, this expansion was often made more difficult due the ongoing economic crisis. As several district administrators commented, in order to open additional and larger health centers, the local health district rented existing buildings from parish governments and local organizations. These buildings often lacked reliable utility services, which was compounded by the district's occasional inability to pay for them. In addition, district administrators noted they were under significant pressure to eliminate rent payments altogether. This sometimes meant that difficult negotiations strained relationships with community leaders. This was the case at P.S. AMUPAKIN, where the lack of a formal contract had meant the MSP occupied the Midwife Association's building without paying rent for the space (only for utilities necessary for the functioning of the clinic). As will be discussed further in Chapter 5, the midwives renewed efforts during the research period to earn rent as an alternative strategy to negotiating monetary remuneration for their work as midwives.

The expansion of services also created a significant need for biomedical professionals, particularly in rural areas where retention has always been low. To ensure medical care in rural areas, in 1970 Ecuador established compulsory rural medical service for all graduates of medical, dental, and nursing schools (Cavender and Albán 1998). These graduates are considered fully trained professionals, but must complete a year of service within the MSP as a condition to obtain a license to practice in the private or public sector. While some preference is given to certain graduates (those who are married, have children, or are disabled), they are randomly assigned to rural job placements throughout the country. There are no medical schools in the Amazon, so all rural-year providers (referred to as "*rurales")* are trained in (and are typically residents of) urban centers in the coast and highlands. Prior to reforms, low pay and insufficient institutional support meant most physicians left the public health sector after the rural year, working in the private sector in urban areas. To increase retention, the Correa government increased wages for all MSP physicians by 80%, and implemented a 20% bonuses for those working in the most remote locations (such as Ahuano and Chontapunta in Napo)(Espinosa, de la Torre et al. 2017).

Despite attempts to increase retention, the recent expansion of care heavily relied on *rurales* to provide services to remote and underserved regions, such as Napo. This was supported by a small number of doctors contracted from the Cuban government, and scholarships for Ecuadorian students to attend medical school in Cuba. At the time of research, approximately 70% of the healthcare providers in the local MSP district were *rurales* (Conversation with District Director, May 2016). The remaining positions (including administrative) were filled through 1 year contracts, with the MSP able to change placements at any time. To maximize cost-effectiveness, the MSP expected all healthcare providers to meet minimum productivity quotas, set at 24 patients a day for physicians, and 16 for dentists. If quotas were routinely not met, the MSP would shift personnel to another location.

To ensure health services were provided to the most vulnerable people, each health center was required to operate medical brigades comprised of an EAIS (1 doctor, 1 dentist, 1 nurse, 1 TAPS) in the communities within their assigned service areas. While the requirements varied based on the number of personnel and remoteness of the communities, most health centers were expected to operate brigades twice a week. For smaller centers like AMUPAKIN, this meant the ability to see patients at the health center was dramatically reduced when brigades took place. For more remote communities, these brigades presented significant logistical challenges for transporting medications and dental equipment. The health center in Chontapunta, at the far edge of the health district, had several communities that were only accessible by hours long canoe rides. Even P.S. AMUPAKIN, located just at the edge of the city of Archidona, serviced two communities that could only be accessed by steep foot trails, where heavy medical equipment had to be carried by hand or horseback. Despite these inconveniences, the brigades were the primary method of monitoring the health status of the 5 designated priority populations: pregnant women, malnourished children, the elderly, people with disabilities, and people with chronic illnesses. This was an important strategy to increase direct access to health services to achieve *Buen Vivir*, and also reinforced the broader neo-socialist reforms of the Citizens' Revolution by bringing institutions to the people (MSP 2009).

As administrators and biomedical providers explained to me, and in my direct observations at P.S. AMUPAKIN, each health center was also expected to hold regular meetings with their local health committee, community schools, and outreach clubs for priority groups (ex. women, children, and the elderly). In these meetings health center staff gave educational talks on subjects designated by the district office, including topics such as patients' rights and targeted public health campaigns for Chikungunya, sexually transmitted diseases, nutrition, and tuberculosis. In meetings with the local health committees (typically comprised of community presidents and occasionally a midwife or other traditional practitioner), health center staff also scheduled brigade visits and *mingas*[36] [community work parties] related to targeted health campaigns. In national health strategies, these outreach activities were considered key mechanisms for fostering citizen participation by providing opportunities to influence health center activities and by encouraging community members to make healthy choices for themselves and their communities.

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[36] Traditionally a part of Kichwa community duties and social relations, the concept of *minga* has been broadly adopted in Ecuadorian society to represent volunteer group work for the benefit of a community or organization.

Other reforms to strengthen community participation and institutional accountability were being implemented just before and during the research period. First, all public health centers were required to collect patient satisfaction surveys, which were reported up the administrative chain to the national MSP offices. Furthermore, the district administration office implemented a service counter where community members could file formal complaints. These complaints were given tracking numbers to ensure the MSP and the complainants could track their status and ensure they were responded to adequately. In addition, the MSP established a centralized appointment scheduling system in 2015, called the Contact Center (located in Quito). Patients would call toll-free to schedule an appointment at their local health center. Prior to this, health centers saw patients on a walk-in basis, which often meant long wait times and turning patients away without being seen. During the fieldwork period, it became mandatory to schedule appointments through the Contact Center. This was seen as a significant improvement by community members living in the urban centers of Tena and Archidona. However, it was a point of contention amongst outlying communities that typically lacked adequate cell phone service and regular transportation to arrive by the designated time.

For the national government, the goal of the Contact Center was to improve the accessibility and efficiency of care, but to also create a system of accountability. The walk-in appointment system used previously was rife with accusations of preferential treatment and racial discrimination, for example making indigenous patients wait longer to be seen. Furthermore, the lack of institutional surveillance meant physicians and other staff would sometimes leave clinics during slow periods, even leaving during their shifts to work second jobs in private hospitals or clinics. While it is unclear how widespread these practices actually were, the Correa administration made it a point to remove “corrupt, lazy, and delinquent” public service employees in all government institutions (El Comercio 2011). In 2011, Correa signed Executive Decree 813 which forced the resignations and early retirements of thousands of government employees, including up to 4,900 health professionals employed by the MSP and IESS (Hidalgo Moreira 2016). While Correa and his political party lauded the move as an important step in the Citizens' revolution (by enforcing ethical and quality standards of practice), many Ecuadorians viewed it as coercive method to remove and intimidate political dissidents.

Efforts to implement Intercultural Health policies were beginning in earnest during the research period. As discussed in Chapters 1 and 3, despite years of development the operationalization of Intercultural Health policies and protocols was a relatively recent phenomenon. An initial wave of Intercultural Health initiatives in 2013 included a census of traditional medical practitioners, training for midwives on signs of risk and referrals to the MSP, and sensitivity training for 52 MSP health professionals on ancestral medicines (Zonal 2 2013). However, all of these initiatives were short-lived, and had concluded by 2014. At the same time, the first PLPPI rooms were established in the region, at the Tena Hospital and the health center at Chontapunta. However, lack of provider training and support meant they were quickly abandoned.

In 2015, a second wave of initiatives began. This included mandatory medicinal plant gardens in all non-urban health centers, and the debut of the first cohort of 77 TAPS graduates. As community health workers selected from within each health centers' services communities, the TAPS's primary roles were to identify vulnerable patients, provide outreach education, interpret medical encounters, and coordinate activities with community leaders. In addition, PLPPI rooms were (re-)established at the health centers in Ahuano, Chonta Punta, and Arosemena Tola. A doctor from each center was given a 3 day training in free position birth at the Cayambe Hospital[37], which focused on scientific evidence supporting vertical birth positions and the practical/technical skills for implementing vertical and humanized birth practices. Despite the presence of midwives and a vertical birthing room, P.S. Amupakin was not officially recognized as a health center providing PLPPI services. This was due in large part to the ambiguous legal status of the partnership between the midwives' association and the MSP. However, as I will discuss in the following section and Chapter 5, it is emblematic of how the ad hoc implementation of culturally adequate birth policies typically alienates traditional midwives.

In summary, government efforts to achieve *Buen Vivir* were noticeably underway during the research period. While most of these reforms were designed to improve healthcare accessibility, quality, accountability, and participation; the Intercultural Health initiatives were also meant to encourage the adoption of local health practices within MSP health centers. However, the remote and often underdeveloped infrastructure throughout Napo often complicated implementation. In the next section, I will examine how these public health reforms are viewed by biomedical providers and community members. In particular, I will address how they view the role of local health services and MSP providers in enacting Interculturality and *Buen Vivir*.

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[37] The Cayambe Hospital was one of the notable pilot projects in intercultural birth within the MSP. The initiative began in 2010 and was funded by CARE Ecuador. Unlike like pilot project at the Otavalo Hospital, traditional midwives in Cayambe were only allowed to accompany but not manage births.

4.2 Enacting Intercultural Health in Clinics

With its embrace of the *Buen Vivir* Plan and discourses of Interculturality, the Correa administration paved the way for more inclusive visions of health and biocitizenship within the new universal healthcare system. As I have noted in previous chapters, the radical transformation of the healthcare system was considered essential to achieving the goals of the Good Life, participatory democracy, and the inclusion of multiple lifeways. By shifting towards a model based on primary and preventative care, the state also strengthened the role of local public health services in enacting those biopolitics amongst everyday citizens.

For local administrators, this meant shaping national level Intercultural Health policies to local contexts while prioritizing limited resources and multiple health campaigns. As such, they play key roles as gatekeepers, both controlling the nuts and bolts of operationalizing policies and enforcing systems of surveillance to track their progress. In contrast, biomedical providers are the primary agents of creating the Good Life by directly intervening in the health of individuals and communities, whether it be managing a free position birth or providing talks on preventing the spread of Zika. They are also the primary source for collecting the data that is compiled for the biopolitical surveillance of *Buen Vivir*. Finally, the TAPS (community health workers) are the catalyst for change, serving as the nexus between their own communities and biomedical providers. In essence, their role is to ensure even the most remote communities are made aware of and fulfill their obligations of biocitizenship to achieve *Buen Vivir*.

In the following sections I will examine the roles of local biomedical services in fomenting *Buen Vivir* and Interculturality through the perspectives of community members and the providers themselves. In the first section, I describe how they frame Interculturality within the transformation of health services and what it should achieve. Then, I examine the frictions between the expectations and realities of how these affirmative biopolitics are operationalized in health services. Finally, I discuss the personal experiences of biomedical providers as they negotiate their duty to enact Intercultural Health policies with their own feelings of precarity. Throughout these sections, I examine how the challenges of creating a biopolitics of Interculturality discussed in the previous chapter become expressed in activities of local health services. First, Intercultural Health strategies came in conflict with other priority initiatives. Second, the required measures of IH policies reinforced cosmetic compliance rather than more radical incorporation of traditional medicines. Thus, despite general support for Intercultural Health policies, their meaningful implementation is often hampered by the same processes of surveillance and evaluation meant to ensure their universal application.

4.2.1 Discourses of Health Services Personnel

Similar to the policy makers and influencers in the previous chapter, biomedical service providers shared a common definition of Interculturality as respect and exchange of knowledge between distinct cultural groups:

> "Interculturality for me is communication, that you learn from different cultures but always respecting the culture of each ethnicity. That we each have different customs that we have to respect." -Dr. Antonia, MSP Obstetrician
>
> "For me, Interculturality is the union of all the cultures that make up Ecuador. Working jointly between cultures for *Buen Vivir*" -Klever, TAPS
>
> "The goal is so that we get to work respecting the cultures, ideals, the customs of the people. It is established in the constitution that traditional medicine and scientific medicine should both be strengthened [reforzarse] conjointly." – Dr. Amalia, MSP District Director of Health Promotion and IH

In slight contrast, however, these definitions of Interculturality tended to be more distinct from one another, clearly representing each individual's own interpretation of Interculturality rather than paraphrasing official policy or academic theory. As I will discuss in more detail, this is most likely due to the separation of local administrators and providers from theoretical discussions of Interculturality as a policy approach.

Similar to policy makers and activists, local health service providers felt the emphasis towards Interculturality in health was emblematic of the affirmative biopolitics and healthcare reforms implemented by the Correa administration. Just as Jefferson expressed, they viewed the adoption of multiple lifeways within biomedical services as a critical component for achieving *Buen Vivir*. This was most strongly stated by the Director of the local MSP District, who was rapidly implementing Intercultural Health policies that had been resisted by his predecessor less than a year before:

> "The community is satisfied because they're no longer forgotten, they're now an active part of society. They're incorporating themselves little by little into a just and equitable society. It's not like before anymore, with forgotten communities. That will never happen again in Ecuador" -District Director, MSP

In addition, providers and administrators recognized that Interculturality was not only about recognizing cultural difference, but also encouraging community participation and interaction with the public healthcare system:

> "Interculturality is about interacting with ancestral knowledges. And fostering environments where all of our cultures intervene to work better together, like with the local health committees" -Dr. Yolanda, MSP Obstetrician

Providers and administrators agreed these changes were both positive, and necessary to achieve the universal right to health as part of the strategy to achieve *Buen Vivir*.

Providers and administrators directly attributed these reforms to the affirmative biopolitics of *Buen Vivir* and the Correa administration. Notably, this even included biomedical professionals who made a point of stating they were not *Correistas* (partisans of Correa's political party Alianza PAIS). As one physician stated,

> "Little by little we're achieving what we want, what this government wants. I'm not a Correista. But there are things like this [community focused care] the government is doing well. It's on a good path. But there are other things that make you want to cry."
> -Dr. Alberto, Private Hospital Physician

For many, this support stemmed from their own first-hand accounts of the healthcare transformation. Nearly all of the TAPS and older, contracted providers recalled how in the recent past public healthcare services in Napo were often unreliable and lacked necessary supplies and staff. They also often referenced their own experiences as recipients of or witnesses to rude treatment of patients by medical providers. While a few of the younger professionals and *rurales*, had similar experiences in their home communities or medical training, most felt the impact of these reforms through the recounted experiences of their patients.

Thus, for biomedical professionals, the most common description of Interculturality in practice was to be respectful of patients' traditional customs and use of natural remedies/ traditional medical practices. They felt this approach was a critical component of broader efforts to provide care with *calidad y calidez* [quality and warmth]:

> "I say keep taking [that tea], but take this too. In other words, include their practices and the knowledge they've acquired from their grandparents with our practices, so they have more confidence/trust [confianza] to come here." – Dr. Fernanda, MSP Rural-Year Physician

In this way, most providers felt an important goal of Interculturality in health was to establish stronger and more positive relationships between providers and patients, as well as between clinics and their assigned communities. This was likely heavily influenced by broader measures of the MSP to incorporate components of patient-centered care in medical education.

While nearly all providers associated Intercultural Health with indigenous traditional medicines, I argue they did not employ a reductionist discourse of Interculturality that views IH policies as only benefitting indigenous communities. For mestizo providers in particular, the culture shock of providing care in rural Amazonia was what first made the necessity of this respect apparent. However, they felt this approach was fundamental for treating **any** patient with dignity, regardless of their ethnicity[38]. Unlike Reductionist discourses that pitted the “exclusivity” of intercutulturality versus the “universality” humanized care/rights to health, Interculturality was seen as a core component of the patient- provider relationship. In this way, the discourses of providers more closely resembled Holistic discourses, by respecting a patients’ right to choose where they seek treatment.

However, I argue the distinction between Reductionist and Holistic Interculturality does not apply to the discourses of local biomedical professionals. On one hand, the rhetoric of indigenous/cultural rights and humanized care was almost entirely absent from all of the interviews I conducted in Napo. What differentiated the view of some providers versus others was not **who** benefitted from Intercultural Health policies, but rather **what** they should achieve. In this way, the conflicts between providers’ discourses of intercultural health more closely aligned with the cosmetic/pragmatic/radical spectrum of discourses discussed in Chapter 2. As will be clear throughout this chapter, all of the providers employed a pragmatic discourse that supported a

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[38] It should be noted however, that with the large indigenous population at the research site (roughly 80%) this combination of Interculturality and patient-centered care was easily made, as nearly all patients were assumed to be indigenous. Comparative studies with centers in majority mestizo settings may produce a clearer distinction between the two.

respect of traditional medicines within the public healthcare system to improve relationships and health outcomes. However, those who employed a more cosmetic discourse felt the ultimate goal of IH was to increase acceptance of biomedicine. In contrast, the slightly more radical discourse described how Interculturality should also strive to support both medicines as equals.

The differences between these discourses are much more subtle than those seen in the previous chapter. However, the distinction was often heard in the ways providers referred to traditional medicines as part of patients' care options:

> "They come from the shamans, they come with their bodies sucked on, they come with a ton of herbs, and **when they didn't have an effect anymore, then they come to us**. So, personally it's not like I dislike that, it's more like I even want to learn more about it to be able to combine it maybe in some way with this medicine and complement it, when its necessary"- Dr. Esteban, MSP Rural-Year Physician

> "Its on us to convince people in the communities that they should take both medicines into account, occidental medicine just as much as ancestral. Like we explain, even with ancestral medicine a lot of people have died too. So we need both medicines, because **you don't know if you'll get better with occidental medicine or if you'll need ancestral medicine too**." – Jefferson, TAPS

Like Dr. Esteban, the biomedical professionals who expressed a more cosmetic discourse tended to describe a strict hierarchy of resort, where patients only accessed the public healthcare system when weaker traditional medicines no longer worked, or their effects at masking symptoms led to more serious illness (see Chapter 5). In contrast, more radical proponents like Jefferson, an indigenous community health worker, felt both medicines were equally efficacious, but not always for the same illnesses. More importantly, they felt that Interculturality in health meant representing both medicines as valid options for receiving care. As described by Ítalo, an indigenous Health Promotion technician, it is "giving a helping hand to both medicines."

Interestingly, proponents of more radical discourses also recognized that patients often only went to clinics in advanced states of illness, but felt that was out of necessity rather than the inherent superiority of biomedicine. For one, limited resources and access to transportation meant natural/traditional remedies were simply more readily available. Additionally, they felt that processes creating loss of traditional practices and knowledge (see chapters 1 and 5) meant that traditional medicines were no longer as effective as they once were:

> "Here in Archidona, the Kichwa shamans were really powerful and well known. We cured ourselves only with plants. But as they die that knowledge is getting lost, the young people like us don't know. I used to walk around here gathering bitter leaves and vegetables, but that's all gone now. You can't find vegetables and things as easily. Its disappearing, you have to go to the urban centers more now." – Klever, TAPS

For this group, increasing patient utilization of biomedical care was necessary in part because of the loss of ancestral knowledge and skills. Thus, they felt Interculturality included the additional goal of (re)generating the esteem and knowledge of traditional practices and practitioners:

> "We're working all over the district with midwives, yachaks, with all of the traditional practitioners. We've already done the famous medicinal plant gardens, so that the community has to return to its ancestral practices. It's about knowing how things were before, how they could cure themselves with their little medicinal plants, for the benefit of the population." -District Director, MSP

For these biomedical professionals, IH policies presented an important opportunity to both bolster traditional medicines, and improve the health of all Ecuadorians.

While the rhetoric often romanticized the healing power of traditional medicines in the past tense, both mestizo and indigenous providers described this goal of Intercultural Health in ways akin to language revitalization efforts (similar to the origins of the concept in Bilingual education). In this way, the MSP would be a protagonist reversing the "death" of rapidly disappearing traditional medicines by promoting their use amongst community members and biomedical professionals, regardless of their ethnicity. This meant both helping indigenous communities "return" to their ancestral practices and getting providers to value and incorporate them as well.

Just as with the divisions among policy makers and influencers, this discursive divide amongst biomedical professionals did not fall exclusively along ethnic nor professional lines. Those who espoused more cosmetic forms were exclusively mestizo, and included rural-year and contracted physicians as well as district administrators. However, those who utilized more radical discourses were both indigenous and mestizo professionals ranging from TAPS to the district director. Again, what distinguished these groups was their direct personal experiences with traditional medicines and other alternative medicines. One mestiza doctor, for example, supported the promotion of traditional medicines because a homeopath had cured her of an intractable rheumatic fever as a child. Likewise, the District Director had himself been delivered by a midwife during a complicated birth. As he said, “we have to pick it up again [retomar] because as I say, I’m a living example of the midwives. We have to give them the space they deserve with the respect they deserve”.

It is important to note these subtle cosmetic and radical discourses were not pure dichotomies. As seen in the quote from Dr. Esteban, many of the biomedical professionals who employed cosmetic discourses were interested in integrating traditional medicines and practitioners into public health services. Also, many of the mestizo professionals who expressed slightly more radical views, such as the District Director, were often unmindful of the ways they could be encouraging cultural appropriation and theft of ancestral knowledge. In this way, these pragmatic discourses of Interculturality tended to lean towards more radical visions that challenged biomedical hegemony, but were ultimately devoid of the political demands of the indigenous rights movement for self-determination over healthcare services. As employees of the MSP, understandably, they emphasized the role that state institutions could play in supporting traditional medicines and vice-versa.

In the following section, I will examine how these subtle cosmetic and radical forms of Interculturality are enacted in the everyday practices of local biomedical health services. While professionals sometimes wished for and even created opportunities for integrating traditional medicines in the public health care system, they were often limited by both a lack of necessary support and the conflicting biopolitical agendas of the MSP. These issues are in many ways the consequences of the policy negotiations detailed in Chapter 3, where the norms and metrics of Interculturality and *Buen Vivir* in health ultimately reinforced the spread and dominance of biomedicine.

4.2.2 Implementing and Evaluating IH in Local Health Services

Policy influencers and makers negotiated multiple discourses of health development and rights as they defined the parameters of how Interculturality in health should be practiced, evaluated, and enforced. In this section, I will examine how those struggles with operationalizing affirmative biopolitics reverberate as new standards are implemented in local health services. The ways local biomedical professionals enact and evaluate Intercultural Health often differed from the expectations created by those institutional frameworks, but are shaped by them nevertheless. In the first sub-section, I discuss how the implementation of the new healthcare system created conflict between IH and other priority health campaigns, including the reduction of maternal mortality that it was meant to support. In the second, I examine how the methods of measuring and reporting Interculturality reinforced cosmetic forms of compliance rather than more radical forms of institutionalized medical pluralism and community participation. For local biomedical professionals, their roles as “providers of health” and collectors of data meant they were directly faced with the challenges of negotiating these conflicts as they directly intervened in the lives of their patients and communities.

4.2.2.1 Conflicting Biopolitics of Care

The biopolitical surveillance of local health services largely revolved around four methods of evaluation: user feedback, health outcomes, utilization/productivity rates, and reports of priority activities. User feedback was primarily judged through patient satisfaction surveys and formal complaints. It also included participatory processes such as local health committees and the annual *rendición de cuentas,* a mandatory public forum for all government institutions at all levels that details expenditures and performance results in priority categories. For health outcomes, the goal was to reduce rates of adverse events such as maternal mortality or childhood malnutrition. Utilization and productivity rates were judged by the number of patient care encounters and included rates of completing recommended preventative check-ups for priority groups (e.x. 5 prenatal checkups). Priority activities were community outreach and personnel trainings designed to raise awareness of prevention strategies for targeted health campaigns. All of these activities were reinforced by monthly reports (called *Gobierno Por Resultados* [Government from Results]) to district and zonal health offices for each of the respective campaigns, as well as through efforts to accreditate all MSP hospitals and clinics.

For clinics, this occurred through the *Servicios Inclusivos* accreditation. To earn the certification, each clinic had to provide 50% of care in brigades and comply with 85% of the standards in four categories: discrimination, contamination, participation, and healthy activities (MSP 2014). The standards for reducing discrimination included activities supporting rights for patients generally and for special populations including ethnic minorities, LGBTQ, and those with disabilities. This category included standards specific to Intercultural Health such as providing

PLPPI services and maintaining a registry of local midwives in each community (see Table 4). The contamination category included activities around proper management of waste and utilization of resources by the clinic. For participation, clinics were required operate local health committees, promote the formal complaint process, and resolve at least 30% of complaints. Finally, standards of healthy activities include patient counselling and promotion activities related to physical activity, and nutrition. Through this accreditation process and the *rendición de cuentas* (which reported on the status of the standards), the MSP encouraged and enforced compliance with the transformation towards community based preventative care.

Perhaps the most obvious conflict between biopolitical agendas (and even between communities and service providers more generally) was the new requirement to schedule appointments through the Contact Center in Quito. For most community members this was the first time they had ever been required to pre-schedule an appointment and arrive 15 minutes beforehand. Understandably, this meant many patients continued to arrive without appointments, and those with appointments often arrived late. As a matter of necessity, the scheduling requirement was generally ignored in remote clinics, such as Ahuano and Chontapunta, where the majority of communities lacked phone service and regular transportation. However, in peri-urban centers such as P.S. AMUPAKIN, the expectation remained despite similar issues for some communities. In addition, the centralized call center was clearly designed for the urban highland population where it was located and was often ill-suited to the realities of life in the Amazon. Appointments could only be scheduled through the call-center and not in person or through direct calls to the local health centers who were more familiar with the communities assigned to them. In attempting to schedule my own appointment at P.S. AMUPAKIN, I could only laugh in resignation while sitting on the steps of the clinic as the operator continued to demand its nonexistent address in order to schedule an appointment.[39]

The call center created significant challenges for both patients and staff. At P.S. AMUPAKIN, the staff frequently turned patients away if they were late or had no appointment, despite being aware of the lack of cell-phone service and transportation. Patients often argued with staff about being denied care, and frequently complained about scheduling issues at the district offices. In addition, the Contact Center often scheduled patients at larger health centers (with addresses!) rather than the health post closest to them. This congested larger centers and created significant difficulties with continuity of care.

Despite the challenges, most biomedical providers felt the appointment system provided a more predictable structure to their day and helped regulate the length of visits. In general, the predominantly urban-origin staff agreed with the goals of the Contact Center to modernize care, noting it was a way to respect the rights of both providers and patients:

> "Before it was super disorganized. That was the main problem we had as professionals, we didn't get the respect we deserved as far as timing and organization. But it's also so we could provide good care, because each patient needs a minimum time to be well cared for and respect their time." – Dr. Fernanda, Rural-Year Physician

For many of them, scheduled appointments led to better quality care and better access to services, both goals of the broader transformation of the healthcare system.

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[39] As is common in many smaller Ecuadorian communities, only the principle roads and highways are named or have have building numbers. In the official registry of MSP health centers, the "address" for P.S. AMUPAKIN is listed as "in the Sábata neighborhood, behind the school".

In contrast to the recent urban transplants, rural-origin staff were more likely to feel that it was necessary to provide flexible scheduling as much as possible. In particular, they felt this accommodation was part of implementing Interculturality in practice:

> "If a patient comes after such a journey, it's because they have a real illness. And if you tell them, 'there's no appointment available' or if you tell them 'come back tomorrow' that's not going happen in my administration. We have to have healthcare that is opportune, when the patient arrives at the health establishment" – District Director, MSP

For these providers, seeing patients on-demand (when reasonable) also meant respecting the challenges they face due to poverty and rural life. It also signaled respect for patients' own evaluation of risk and agency in managing their own well-being.

For patients, being turned away felt they were denied their right to services and/or were abandoned in times of need. While some of them were aware of the new ability to lodge formal complaints, most of them voted with their feet. Especially in (peri)urban areas, patients would ignore their designated community clinic to schedule at other locations where providers were perceived as more caring, friendly, and flexible.

However, even providers who supported the implementation of the Contact Center felt it ultimately served as a method to enforce production quotas for health centers. Providers felt the number of patients needed to justify their job placements were too high to provide the intercultural and warm care expected of them:

> "All the MSP cares about is the quantity of patients. They don't care about the quality of how you care for them. They only ask for numbers and goals, and numbers and goals. I honestly don't have the incentive to tell the patient 'I'll do everything I can to help you'. With only 20 minutes, I prefer to just treat her illness, and go on to do all the other things I have piling on top of me".- Dr. Esteban, MSP Rural-Year Physician at P.S. AMUPAKIN

In this way, providers often identified a direct conflict between the MSP's goals to improve the patient/provider relationship and increase the number of primary care encounters.

This tension was also felt to exist within the evaluation methods for each process. As Dr. Esteban indicates, meeting expected production levels would likely mean an increase in formal complaints and a decrease in patient satisfaction. Balancing these expectations was a constant point of stress for providers, particularly for the increased staff at P.S. AMUPAKIN who had to quite literally justify their own positions by meeting their patient quota.[40]

This perceived conflict between the affirmative goals of Interculturality and biopolitical methods of measurement and control was not unfounded. According to several district administrators, disputes over appointment scheduling were the primary topic of formal complaints. If the district noticed discrepancies in appointments or detected negative satisfaction ratings/complaints, the health center was required to complete a Quality Improvement process to identify and address the issue. This enforcement was considered a key component of achieving the quality of care demanded by the Citizens' Revolution. But it also reified patient satisfaction as primary indicator of Interculturality in health, rather other measures of inclusion. For example, during a meeting with a local health committee, the then district director ended by stating that "to achieve *Sumak Kawsay* the fundamental objective is to have the satisfaction of our patients in the health services." Thus, the strategy of increasing patient access to care was in direct conflict with one of the core measures of Interculturality.

The primacy of quantitative utilization measures was particularly clear in discussions of the new model of community-based care. In this model, local service providers were expected to

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[40] Despite Dr. Esteban's pessimism, community members felt he and the other new rural year providers at P.S. AMUPAKIN were especially good at providing patient-centered care, and caseloads more than doubled during the research period.

track priority populations in order to monitor their health and encourage them to complete the recommended preventative health check-ups. As all of the district administrators I interviewed (n=4) made clear, the most essential goal of the new healthcare system was to "*captar"* [capture/gain/attract] all community members within institutional health services:

> "Each health establishment has around 1200 residents. So, all 1200 residents need to be cared for. We can't leave one patient without being seen. Our vision is to capture the patient and give them an exhaustive monitoring. That is integral care. Only when we do that can we say we've achieved our task." – District Director, MSP

> "There shouldn't be any pregnant patient in any community that isn't captured. And they need to make sure she goes to her checkups until the child arrives so there aren't any problems for the child or the mother." – Dr. Isabella, District Coordinator for Plan for Reduction of Maternal Mortality

As the quote from Dr. Isabella highlights, this especially applied to priority groups at the center of targeted state health campaigns such as the Plan for Accelerated Reduction of Maternal Mortality. The new MAIS-FICI healthcare structure and its supporting initiatives were specifically designed for this purpose of "capturing" new and high-risk patients. All MSP clinics maintained a "census" of priority populations in each of their assigned communities which were monitored at the district level. The MSP even contracted Cuban physicians, and established both the TAPS and a new specialty in Family, Community, and Intercultural Medicine (MFCI) - all with the primary purpose of identifying, monitoring and treating priority populations.

For administrators, this surveillance based approach was considered an essential strategy for implementing preventive health care:

> "It's a priority of the state to do prevention rather than curative care. The population needs to be in contact for prevention checkups to minimize illnesses and operations. That's how we're going about the goal of prevention. and we're not going to rest until we reach that." -District Director, MSP

For this reason, providers in local MSP clinics were under considerable pressure to maintain accurate registries of priority patients and whether or not they had completed recommended checkups. As I witnessed often at P.S. AMUPAKIN, the district offices would call the clinic coordinator (one of the rural-year physicians) asking about specific patients who had not fulfilled the recommended prenatal appointments. The coordinator would then either notify the team to locate the woman during the next brigade, or would send a TAPS directly out to the community to locate her and immediately set up an appointment at the clinic.

However, this preoccupation with surveillance and care utilization often overshadowed efforts to establish intercultural relationships with communities and traditional practitioners. This was particularly evident in the expected roles of traditional midwives and TAPS. As other researchers have noted elsewhere (Jordan 1997, Pigg 1997), state policies towards traditional birth attendants generally emphasize signs of risk and the importance of referring patients to biomedical institutions. At least discursively, Intercultural Health in Ecuador challenged that power imbalance through pilot projects (ex. Otavalo Hospital and AMUPAKIN) and policies (APKAM Manual) that prioritized mutual learning and care referrals. However in practice, local biomedical professionals often defined the roles of midwives as intermediaries in the surveillance process:

> "It's a lot easier for us to try to convince or instruct a midwife in what they need to identify than it is for us to try to convince an entire community to come here to the hospital… Its easier to train the midwife so refers to us whatever things she sees that aren't good" - Dr. Marcela, MSP Hospital Gynecologist

Particularly for providers employing more cosmetic forms of discourses, the relationship between local MSP services and local midwives was primarily funneling care to the MSP rather than mutual care of patients.

Alternatively, those who employed more radical discourses were more likely to value the skills of midwives as providers in their own right. One example comes from Dr. Sisa, a Sierra Kichwa rural-year physician working in a clinic implementing PLPPI:

> "The midwives send patients here, because they've had the trainings. Or they'll call us and tell us what's going on. You give them the trainings and more importantly **you give them that recognition that I think incentivizes them more and they become more connected [vinculadas]**. But, I do think there needs to be more work to give them more relevance, because **if they just bring patients here and we see them, that ancestral knowledge is going to be lost**." – Dr. Sisa, MSP Rural-Year Physician

Here, Dr. Sisa makes an interesting pivot from a more cosmetic to more radical form of Interculturality. In the beginning, her perspective is very representative of nearly all the biomedical professionals I interviewed. In this view, Interculturality is a tool for increasing biomedical surveillance. By showing respect for traditional beliefs and practitioners, patients would more willingly come to receive care, and midwives would more willingly refer their own patients. However, at the end she recognizes that in doing so the MSP is ultimately encouraging them to willingly render themselves obsolete.

Likewise, for TAPs their primary role was regularly described as being the nexus between MSP clinics and their assigned communities. Both the MAIS-FICI and local providers referred to TAPS in ways that presented them as the personification of Interculturality in practice: discussing prevention and treatment in the native language, opening channels of communication between community leaders and clinics, and maintaining relationships and referrals with traditional practitioners. Despite hiccups from the recent implementation of the program, providers and administrators highly valued the work of TAPS, often stating that their work was essential to establishing strong and trusting relationships with surrounding communities who remained suspicious of historically unreliable and discriminatory MSP services. However, both the MAIS and district administrators underscored that the ultimate purpose of all of these activities was to maintain an accurate patient census and increase utilization rates.

This is perhaps most obvious in the perceived conflict between the TAPS and the defunct position of *promotores de salud intercultural* [intercultural health workers]. This position existed between 2013 and 2014, and was managed by the zonal administrator of Intercultural Health. Although I was unable to find any documentation or policies specific to this program[41], I was able to see it in action during preliminary research in 2013 and interviewed 2 MSP staff who had worked in that role but were now employed in Health Promotion and as a nurse's aide. These intercultural health workers were recruited from indigenous communities and assigned to local MSP clinics. Their primary tasks included: creating a registry of traditional providers and establishing medicinal plant gardens at each health center, training midwives in antiseptic practices and signs of risk, creating a bilingual medical dictionary in Napo Kichwa (for providers), compiling a digital repository of medicinal plants and their use, and providing outreach education to community members on preventive health practices (including biomedical check-ups).

As Ítalo (now a health promoter at an MSP clinic) described his previous role,

> "the most important part was raising awareness, revitalizaing [revalorizando] our medicines so the young people have that knowledge. Back then there was a lot more exchange of experiences. It was a beautiful process, but they're not working in that anymore, there are other policies now."

As he described, the program was ended by the previous Zonal Coordinator and District Director. In my own informal interactions with them in 2013, both expressed that traditional medicines were only for indigenous communities, and had little role to play in improving biomedical care. As

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[41] As I was unable to find any documentation of this position, it is unclear whether it was only implemented in MSP Zone 2 or if it was implemented nationally through the then directorate of Intercultural Health.

another district administrator explained, the program was ended in large part because it did little to improve patient utilization rates. In her view, this was due in part to the lack of scientific biomedical training required of the intercultural promoters (as compared to TAPS). Instead, efforts were shifted to recruiting TAPS, who complete 3 years of training within the MSP, and fulfill some of the same tasks, and directly “capture” patients from the community. While the role of the IH promoters focused directly on reinforcing indigenous cultural values, those same activities lacked direct connection to existing biopolitical agendas prioritized by the state, and no new metrics of “culture” or its influence were created to establish more directly inclusive biopolitical agendas. As the first cohort of TAPS graduated, their direct impact on those agendas gave them much higher priority, ending what was perhaps the most widespread effort by the state to promote indigenous medicines.

Unlike the intercultural promoters, the TAPS program was not under the purview of the national MSP Intercultural Health Office. Furthermore, none of the TAPS I interviewed (n=4) received any training in the principles of Interculturality nor the Intercultural Health initiatives that were being implemented by the MSP. Thus, a more radical and explicitly intercultural approach designed to promote traditional medicines was quite literally supplanted by a more cosmetic and implicit approach of Interculturality that reinforced biomedical utilization in achieving the Good Life and fulfilling the obligations of biocitizenship.

The final clash of biopolitical agendas was the most concerning for biomedical providers and administrators who supported more radical approaches to intercultural health. In brief, the push to achieve zero maternal deaths significantly undermined the utilization of the new PLPPI birthing rooms that were intended decrease maternal deaths in the first place. In Napo, the MSP prioritized implementing official PLPPI rooms in the large, but remote, clinics in Ahuano, Chontapunta, and Arosemena Tola. According to providers at those clinics, roughly 50% of women in their community networks gave birth at home, significantly higher than the national and even regional average. Understandably, these were considered priority populations for intervention. The informal birth room at P.S. AMUPAKIN was an exception, as its location was based on the midwive's association rather than the central MSP planning office.

The rationale was to use the rooms to both decongest the hospital, but more importantly to reduce the three delays of maternal mortality: 1) deciding to seek care in an obstetric emergency, 2) arriving at an appropriate facility in time, and 3) receiving adequate care upon arrival. By having the facilities close to remote communities, they could dramatically reduce delay number 2. And, by implementing intercultural birth policies that accommodated traditional practices, they could reduce delay number 1. However, community members and biomedical providers at those clinics had serious reservations about those assumptions, particularly for delays 2 and 3.

In regards to delays in reaching a facility, many of the community members still faced issues of transportation despite the closer geographic proximity of the clinic (compared to the hospital). In Chontapunta, many of the communities were just as remote from the clinic as they were from the hospital, requiring hours of canoe rides and walking on footpaths. And for the communities with road access, it was often easier to hitch rides to Tena than to the clinics, as was also the case in Ahuano.[42] For this reason, the women who did give birth at the PLPPI clinics (approximately 25%), were predominantly mestiza *colonos* [settlers] from the more populated neighborhoods immediately surrounding the clinics. Furthermore, the clinics frequently lacked

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reliable transportation to relocate patients to the hospital (a 1-2 hour drive depending on location) if serious complications did occur.

Biomedical providers at the PLPPI clinics and P.S. AMUPAKIN also questioned whether they could truly provide adequate care as outlined in delay number 3. While they had access to handheld fetal heart monitors, Pitocin, and medications for managing hemorrhage; they lacked other materials necessary for obstetric and neonatal emergencies such as oxygen, incubators, and resuscitation equipment. In addition, the reliance on rural-year physicians meant most of the providers attending PLPPI births had little experience with births of any kind:

> "When you're in the hospital there's the neonatologist, the anaesthesiologist, the nurses, the obstetrician, the doctor. So you have a support team. But here if something happens, I'm all by myself so its like, 'AHH who can I ask for help?'" – Dr. Lena, MSP rural-year physician
>
> "DS: Our hearts are in our throats and we almost have a heart attack every time we manage a birth here. Honestly, I think it's safer for them to go to the hospital, because if something happens they're with the specialists. Here,--
>
> -- DC: they're alone [laughs nervously]
>
> DS: basically, yeah."
>
> - Drs. Sisa and Camila, MSP rural-year physicians

All of the biomedical providers I interviewed who had worked at a PLPPI clinic felt their limited birth training in large urban hospitals left them unprepared for deliveries in rural clinics with almost no clinical support. This was also demonstrated in a survey of rural-year physicians in Southern Ecuador that demonstrated a significant gap between skills deemed necessary for rural obstetric care and experience during residency. For example, 3% of respondents had only practiced cervical dilation checks once during residency, and 6% had neither seen nor performed the skill (Sánchez del Hierro, Remmen et al. 2014).

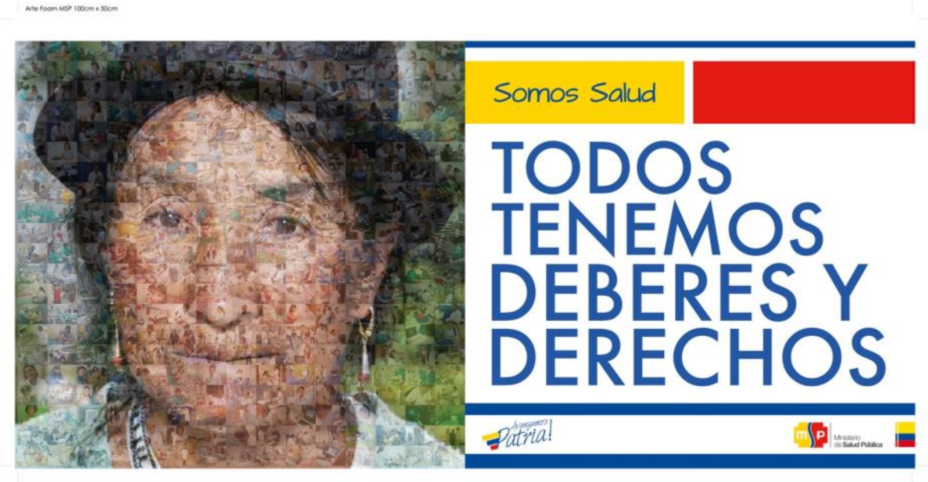
The concerns of patients and providers were heightened by longstanding campaigns urging women to deliver at the hospital in case of emergency, especially for high risk populations.

Providers, for example, were well aware that the same limitations of transportation meant the majority of their patients had received minimal prenatal care and no prenatal ultrasounds (only available at the hospital) to pre-determine risk during delivery. Community members likewise felt that the hospital was the only place equipped to deal with any significant complication.

Therefore, the success of raising awareness of risk for maternal mortality significantly limited the proportion of deliveries performed at PLPPI clinics and P.S. AMUPAKIN. According to providers at all locations, women who came for prenatal checkups (and were likely the most aware of the PLPPI option) were also the most likely to give birth at the hospital. Thus, the majority of births done at the official PLPPI clinics were actually home births that had stalled in active labor, but would likely not reach the hospital in time.

In contrast, women who came to P.S. AMUPAKIN often arrived in earlier stages of labor. However, every delivery I witnessed that occurred with doctors present was referred to the hospital before the baby was born. In later interviews, the doctors all cited fears of slight complications (such as stalled deliveries) becoming too complex for them to manage. In one case, the contracted obstetrician felt labor was stalling for too long and attempted to set up an IV to administer Pitocin. However, the obstetrician's hands were shaking so badly she could not place a line, and both the rural-year physician and nurse admitted they would not be able to do it. With the obstetrician's insistence on Pitocin, the midwives called a taxi to transfer the patient to the hospital. Thus, for providers and the majority of patients, the push to reduce maternal and neonatal mortality overwhelmingly encouraged birthing at the hospital in Tena, where PLPPI and its concomitant intercultural and humanized birth practices were not available.

At the heart of these points of friction between Interculturality and the transition to universal primary healthcare was a conflict over responsibility for achieving *Buen Vivir*. As discussed in the previous chapter, both the biopolitics of the state and the mechanisms of control



We are Health

We all have duties and rights.

[Photo of woman in highland Kichwa dress].

Figure 3. Mandatory Waiting Room Rights Campaign Display

within local public healthcare services reinforced a co-responsibility for health. This was especially reinforced by the accreditation process, which required all clinics to display signs and give talks about rights and obligations in health (see Figure 3). While it was the responsibility of the state to provide free services and respect patient's rights, it was the responsibility of patients and communities to comply with the new standards of prevention, treatment, and participation:

> "More than anything the challenge is the culture that is here. we go out to the communities and give prevention talks, **but health isn't important to the people here**. It's not like the people really follow to the letter everything the doctor says." – Dr. Martin, MSP Rural Year Dentist
>
> "A lot of **times they take their rights but don't fulfill their obligations**. Like it's an obligation to arrive 20 minutes before an appointment from the Contact Center. It's an obligation to take the medication as a doctor prescribes. If a woman doesn't rest like a doctor told her and she has a miscarriage, it's not the doctors fault. It's because she didn't fulfill her responsibility. **We need to empower patients so they can fulfill their obligations**." – Dr. Yolanda, MSP District Director of Human Rights

As these quotes and the previous discussion highlight, these obligations of citizenship were inherently biomedical. While processes of community participation and intercultural adaptation were meant to respect and respond to patients' lived reality, the purpose of their existence was to increase acceptance of biomedical care and surveillance. As the District Director, a proponent of more radical forms of institutional medical pluralism, stated:

> "The goal is to make a single society, to work as a family. So that with pleasure the patients go to the health center with a smile, and leave likewise with a smile."- MSP District Director

Ultimately, the policies of the new healthcare system favored a vision of the Good Life that was quite literally defined by biomedicine. In this way, affirmative discourses of incorporating plural lifeways served to reinforce biomedical institutions as the most legitimate form of care, making it even more "legitimate" for indigenous peoples who were previously marginalized from and by those services.

4.2.2.2 Compliance vs Revitalization in Intercultural Health Services

Despite the general subordination of Intercultural Health initiatives to targeted health campaigns and system reforms, they were being implemented more widely than ever before. This renaissance of Intercultural Health policies in Napo was due in part to the new district director, who strongly supported a more radical vision of Interculturality. However, this expansion was also due to the creation and enforcement of new protocols and methods of surveillance by the national Intercultural Health office (see Chapter 3) and the accreditation process for MSP clinics. In this section, I will examine the biopolitical implications of how nominally Intercultural policies were implemented and tracked in local healthcare services. In particular, I demonstrate how the data reported to the zonal and national offices were seen to prioritize the completion of specific activities rather than building lasting mutual relationships with indigenous communities and traditional practitioners.

The standards for the *Servicios Inclusivos* accreditation were the only universally mandated Intercultural Health initiatives in local health services. As outlined in Table 4[43], the standards are considered minimum requirements for eliminating discrimination in local health services, and more specifically for providing coordinated care for diverse populations.

Table 4. Intercultural Health Standards for *Servicios Inclusivos* Accreditation

Standard	Description
1. Intercultural Information	The clinic displays health indicators segregated by ethnicity for child malnutrition, teen pregnancy, and a locally significant category
2. Intercultural Training	At least 95% of clinic staff complete course on Interculturality in health
3. Registry of Midwives	The clinic maintains a list of midwives in each community
4. Staff Diversity	The clinic maintains a list of personnel including their self-identified ethnicity
5. PLPPI	Where applicable, the clinic provides PLPPI services

Standard 1, for example, is meant to raise public awareness of local health priorities as they relate to different ethnic groups. And Standard 4 is meant to provide transparency about whether the local healthcare workforce is representative of the population it serves. Finally, Standards 2, 3 and 5 reinforce initiatives created by the national IH office. However, Standard 2 was not applicable as the course had not yet been completed by the national IH office. Additionally, Standard 3 did not mandate interaction or cross-referrals with midwives. Instead it served as assurance that clinics were in contact with midwives to refer high-risk patients. There is also a noticeable lack of standards for other IH initiatives, such as the medicinal gardens. Perhaps most importantly, clinics only needed to comply with 85% of the standards to achieve accreditation, which meant they were able to earn certification regardless of their inability to comply with several of the standards. Despite establishing an important point of evaluating compliance, the standards did little to

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[43] Adapted from interviews with district staff and MSP training materials MSP (2014). Derechos Humanos y Salud Inclusiva. G. e. I. Direccion Nacional de Derechos Humanos. Quito, Ministerio de Salud Publica del Ecuador.

promote the use of traditional medicines either in communities or health establishments. Instead, they served to support other priority campaigns such as reducing maternal mortality and teen pregnancy.

Although not required for accreditation, medicinal plant gardens were considered obligatory for all primary care clinics outside of urban centers. Clinic staff were expected to create the gardens in partnership with their local health committees, and had to submit a report featuring a list of plants and their use, as well as photos of the *minga* in which the garden was constructed. As an incentive, the district office notified clinics it would publicly recognize the "best"[44] garden in the annual *rendicion de cuentas* [public performance review forum]. The MSP staff at P.S. AMUPAKIN were also expected to construct their own garden immediately adjacent to the health post, even though the midwife association maintained a large traditional garden[45] at featuring medicinal plants.

District administrators viewed the implementation of the gardens along the same affirmative lines as the national Intercultural Health office. First, the involvement of local health committees meant it was an additional point of contact to encourage participation between community members and clinic staff. Second, it was a direct method of rescuing and promoting local traditional knowledge. Third, it encouraged a mutual dialogue of health, where biomedical practitioners were *sensibilizados* [made aware, made sensitive to] in local practices.

However, the implementation of the gardens did not always match the aims of the project. In Chontapunta, the TAPS worked alongside several of the local health committee members to

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[44] The criteria for what constituted "best" was never shared. At P.S. AMUPAKIN staff took it to mean the prettiest garden with the most decoration.

[45] A mixed-use permaculture garden featuring plants used for medical, decorative, and

establish the garden. However, at several other clinics the gardens were mostly built by the TAPS, with little or no involvement from community members. This was the case at P.S. AMUPAKIN, where the garden was almost exclusively constructed by the indigenous staff (TAPS, receptionist, and pharmacy technician). The midwive's association (of which the receptionist was also a member) donated most of the plants, but they were not involved in the design or planting of the garden. After the garden was built, the staff who were present asked the on-duty midwives to join for the picture that was sent in with the report. Some of the rural-year staff were curious about the garden and its plants, but the interest never progressed past explanations of "this is X, we use it for Y". During my nearly 11 month residence at the clinic, I never saw a physician nor patient use plants from the garden. Interestingly, both the TAPS and doctors responded to my initial question about the garden with the phrase, "there really isn't one here". Even more telling, the overwhelming majority of community members I interviewed were unaware that the gardens existed at all.

These differences between intent and practice hinted at more serious issues behind the medicinal gardens and intercultural policies more generally. For one, the lack of guidance beyond the requirement to submit a report did little to monitor or enforce true community participation. Even at the clinics where community members did participate, the district had received complaints about how what that participation meant in practice. As one district administrator explained:

> "There's been resistance on the part of the communities. Some criticized it because they didn't recognize all the plants, but we had to plant things that both the community and the doctors would recognize. Others didn't want to participate because they didn't have time or weren't going to be compensated for their work." – Dr. Isabella, District Coordinator for Plan for Reduction of Maternal Mortality

As the quote indicates, community members often felt alienated or ignored when plants widely used in Napo were left out for alternatives that were more widely known in the Sierra and Coast where most of the biomedical professionals were from. For them, this showed a lack of willingness to learn about local practices and instead demonstrated an accommodation for the providers. In addition, they felt the significant time and effort required to travel to the clinic, cultivate seedlings, create signage, and maintain the garden meant giving up valuable time for income-generating activities. This often meant low-participation of community members in *mingas* for other health campaigns as well. In turn, this lack of participation limited the potential for mutual dialogues and participatory governance between communities and providers.

While biomedical providers and community members liked the idea of having medicinal gardens to be utilized at health centers, they ultimately felt they were empty gestures unless their use was encouraged by the clinic staff. However, most of the indigenous staff were not involved in treatment roles, and non-indigenous staff felt they did not know enough about the plants to be able to recommend their use:

> "The TAPS brought the little plants because they're the ones who know them the best, the midwives gave us some little plants and all that. But that's where it ended. If you asked me what each plant does, I have no idea. They told me, but I don't remember. Because in my way of life, in my culture we don't use them. But if you ask me what penicillin is for I can answer you. We don't know what effect they have, or what dose to give." – Dr. Luisa, MSP Rural-Year Physician

Although the gardens served as a point of contact where mestizo providers could learn about local remedies and practices, this point of connection was superficial and fleeting, as Dr. Luisa describes. Understandably, providers felt these interactions were not sufficient training for them to actively incorporate medicinal plants in their own practice, even when they strongly believed in their power to heal.

In interviews, providers often commented on the lack of training in local beliefs and plant use, particularly those who employed more radical approaches of Interculturality. Of the 23 providers I interviewed, only 2 had received any formal training in the use of medicinal plants.

This included one rural-year physician who attended workshops during residency in Otavalo, and another rural-year physician who was trained in Traditional Chinese Medicine as part of her medical school education in Cuba. Notably, this meant that none of the curriculum for the TAPS informed about or even promoted the general use of medicinal plants. While it was likely assumed that they were already familiar with their own local practices, several of the TAPS I talked with acknowledged widely ranging levels of traditional medical knowledge as many of them were part of the younger generation that had less access to forests and traditional methods of learning.

In addition, mestizo providers' lack of knowledge about local customs meant they also felt less capable of participating in the project. Thus, the gardens represented one of the ways in which intercultural activities were offloaded onto indigenous staff, particularly the TAPS, who were already more familiar with local customs and beliefs. Rather than creating a point of mutual learning, the gardens reinforced a cosmetic demonstration of accepting indigenous practices. Ultimately, providers recognized that what mattered most to the MSP administrators was simply that the gardens existed, not that they were built in cooperation with the community or even used.

Similar issues were also present in the implementation of the rooms for *Parto en Libre Posicion con Pertinencia Intercultural* [free position birth with intercultural pertinence, or PLPPI]. In addition to the lack of general obstetric training and experience, biomedical physicians and obstetricians lamented the absence of training for non-lithotomy position births. At the time of research, none of the medical schools in Ecuador had ever offered courses in managing vertical or humanized births. Of the 7 physicians and obstetricians I interviewed who managed births at PLPPI clinics and AMUPAKIN, only 2 had received any formal instruction in vertical birth positions, culturally appropriate care, or PLPPI equipment such as birthing chairs or suspended cords. One contracted obstetrician had attended the 3 day training in Cayambe. The other doctors who attended with her at the time had completed their rural year of service and were no longer practicing in Napo province. Another contracted obstetrician, who had worked at P.S. AMUPAKIN, was sent to shadow the doctors and midwives at the Otavalo Hospital in 2012[46]. However, no births occurred during her stay, so she was only given demonstrations by staff. In addition, one rural-year physician had witnessed a vertical birth (but received no training) as part of her medical training in Riobamba, where a PLPPI room had recently been implemented.

Although all rural-year physicians were expected to be able to attend births at AMUPAKIN and PLPPI centers, they typically delegated the task to whichever female provider had the most birth "experience". The administration was aware of this issue and attempted to place the most experienced contracted doctors at the PLPPI centers, but was limited by the high proportion of rural-year providers in the district and the lack of funds to continuously send new doctors to Cayambe for training.

As one doctor said, "they tell you to do an intercultural birth and you're like, 'HOW?!'". For providers, this training was essential as non-lithotomy birthing positions significantly impacted the nature of the birth and their roles as providers:

> "I was so afraid at first because if the patient wanted to sit or go on their knees to give birth I didn't even know how to catch the baby. And the babies come out a lot faster in those positions. There can be accidents like the baby falling to the floor if you aren't fast enough"- Dr. Antonia, MSP Obstetrician

> "Its basically an obligation to attend births here. But if we're gong to do this kind of care we have to have to the room implemented really well. Its not just saying, oh I have this and this and its all good." -Dr. Sisa, MSP Rural-Year Physician

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[46] Before the establishment of the training program in Cayambe and the formal implementation of PLPPI rooms nationwide.

As several mentioned, their training in lithotomy birth was much more comfortable for them as providers, but intercultural birth prioritized the comfort of the patient. While they all felt this change was important and much needed, their ability to make it happen safely was limited by the lack of training from the MSP. In two of the centers, this meant that providers only recommended seated births, as it was the most predictable and similar to the lithotomy positions with which they were trained. Rather than the goal of "free position birth" and increasing patient autonomy in the birthing process, the unsupported implementation of PLPPI meant providers selectively implemented the moderate changes they personally felt comfortable with.

Much like with the medicinal gardens, providers felt this meant the implementation of intercultural birth prioritized cosmetic compliance through measures of production over more meaningful and comprehensive changes to biomedical practice. However, the pressure to increase the number of PLPPI births was significantly greater. For the MSP, the additional costs of equipping the rooms and creating the standards of culturally appropriate care were only justifiable if they were cost-effective. In other words, the implementation of PLPPI was only valued if it decongested hospitals and reduced rates of maternal and neonatal mortality. This was primarily measured by total number of women giving birth at the PLPPI centers. As the providers and administrators informed me, the district met with the formal PLPPI clinics warning them their production numbers were too low. In Chontapunta and Ahuano, for example, the clinics were managing 1-2 PLPPI births a month, while their expected rates (based on patient population) were 5 and 12 births per month, respectively. As one doctor explained, "they've let us know that we need to try to *enamorar* [win over/make fall in love] at least that many patients to come here to give birth to justify our positions."

In contrast, the unofficial birth room at P.S. AMUPAKIN meant there was almost no surveillance over the number of births managed there. For those providers, there was little incentive to manage births at the clinic, as they could both limit their own patient production and pose unnecessary risk. For this reason, whenever the midwives were not present and a women arrived to give birth, they immediately transferred her to the hospital. Unlike Ahuano and Chontapunta, whose remote locations necessitated on-site provider housing and 24-hour care, the clinic at AMUPAKIN was only open during regular business hours. This meant that biomedical providers typically were not present at births that occurred after 5pm or on weekends (the majority of births). Although the midwives called the doctors to notify them, they would refuse to come (particularly rural-year docors). If the patient had given birth by the morning, the doctors performed neonatal and post-partum checkups. However, in the 2 cases I witnessed where the patient was still in labor, the doctors transferred them to the hospital over potential safety concerns, despite not having been present for the majority of the labor process. In situations of non-emergent care, such as prenatal checkups or *limpias* [spiritual cleansings] the providers did not participate as they had to care for their scheduled patients that would contribute to their production numbers. Therefore, the uneven enforcement of biopolitical surveillance effectively maintained separation between the clinic and midwives' association operating within the same building.

The doctors at P.S. AMUPAKIN also noted that the informal nature of the agreement with the midwives' association created messy relationships of provider responsibility that further disincentivized integrated practice with the midwives:

> "I can't say, 'Ma'am you can go here to the midwives' because if something happens, damn. Its on you, you know?"- Dr. Esteban, MSP Rural-Year Physician

> "One time I came during a birth and the baby was born with an omphalocele. If the baby died there it would've ruined my reputation. They would've asked me why I

> didn't check her file and ultrasounds first. But not with the midwives, because they're justified in not knowing all of that." -Dr. Yolanda, MSP Obstetrician

As these quotes show, when patients came to deliver with the midwives, the midwives were their chosen primary provider even though legal responsibility of care fell on the doctor who signed the clinical chart. For the biomedical providers, this created a difficult legal position of responsibility that was not address in neither the informal agreement with the MSP nor the minimal training the obstetrician had received. While the lack of appropriate prenatal screening was also common at the formal PLPPI centers, the majority of women who came to deliver at AMUPAKIN did not belong to the clinic's assigned communities. Instead, they tended to hail from the same communities as the midwives (located throughout Tena and Archidona), or came because of the notoriety of the association. This meant most of the women who arrived to give birth were completely unknown by the staff, unlike the women who delivered at formal PLPPI centers who would see the women during brigades or were informed of potential risk by TAPS and other community members.

These variables of training, geographic isolation, and liability for care meant each establishment negotiated the integration of traditional practitioners in remarkably different ways. In the formal PLPPI centers, both the biopolitical surveillance of production and geographic isolation meant that doctors were both professionally and morally obligated to manage births at the clinic despite the risk. In contrast, the lack of minimum birth rates and proximity to the hospital allowed the doctors at P.S. AMUPAKIN to avoid potential risk to the patients or themselves by transferring them to the hospital with minimal collaboration with the midwives. When there had been an obstetrician at AMUPAKIN, she was more willing to collaborate with the Midwives during births regardless of the hours of operation. However, she admitted this was in large part due to her training at the integrated midwife/obstetrician program in Otavalo, and the fact that when she started at P.S. AMUPAKIN it was the exclusive (and much lauded) provider of vertical birth in all of Napo Province.

Experience and training were important differentiating factors between the formal PLPPI clinics in Ahuano and Chontapunta as well. In Ahuano, the obstetrician who had received training in Cayambe attended births as outlined in the PCA Guide: where midwives were present at births if they arrived as the companions of the patient. In contrast, the inexperienced rural-year physicians at Chontapunta had partnered with a nearby midwife they would call to help them manage births. The differences in the relationship with midwives are clear:

> "Here, the midwives mostly just talk with the patients in Kichwa, giving them fortaleza [strength/fortitude] so they push. But all the other procedures are done by us."- Dr. Antonia, MSP Obstetrician
>
> "She tells us if the baby is in a good position or not, repositions the baby, and does things to help the baby come out faster, like change the mothers' position… We give each other ideas and make decisions together. She's gotten the baby while I've watched, and vice versa. It's not like she's in the corner watching. She's in there and wears the protection and is at my side." -Dr. Camila, MSP Rural-Year Physician

In the clinic with a trained biomedical provider, the midwives' role was similar to that of a doula, providing emotional support and physical comfort. However, in the clinic with inexperienced providers, they relied heavily on the practical experience of the midwife to provide the skills and confidence that they lacked:

> "DC: With the midwife its like having a second opinion. For me it's important that she's part of the team attending with us.
>
> DS: yeah, those births have been relaxed, because you feel supported. The midwife is a big help, hopefully she doesn't go."- Drs. Camila and Sisa, MSP Rural-Year Physicians

As their discussion indicates, these doctors felt that the presence of the midwife at the clinic mitigated potential risks. While these comments express the value of traditional midwives in filling different kinds of care roles, it also highlights how the nature of the doctor-midwife relationship is dependent upon the doctor's will. Interestingly, unlike the doctors at P.S. AMUPAKIN, they left out any discussions of professional liability. I argue this is most likely due to both their inability to transfer care, and because of their clear responsibility as the official provider at the clinic. Regardless, the doctors at Chontapunta considered the midwife an essential part of the care team, paying her out of their own salaries for each birth, and even advertising her presence during promotional visits for community members.

Although it is easy to assume the differences in implementation were a matter of whether a provider supported a more radical form of Interculturality or not, it was not so clear cut. While the doctor at Ahuano employed a more cosmetic form that limited the role of midwives to community liaisons, providers at both Chontapunta and P.S. AMUPAKIN supported more radical forms albeit in very different ways. Despite being hesitant to collaborate directly with the midwives, the biomedical staff supported their efforts to renegotiate and formalize the agreement with the MSP district office. This included one of the doctors setting up meetings with the new District Director, who dreamed of turning the location into a formal training center for PLPPI births. This led to meetings with a lawyer to settle pre-existing property disputes, a professionally filmed traditional birth demonstration that the district intended to use to convince the local governments to pay for remunerations for the midwives. In contrast, the rural-year providers at Chontapunta felt it was their duty to remunerate the midwife for her work, but did not try to establish a more formal or permanent relationship through the district that would maintain that relationship after their service years ended. Ironically, this meant the providers at Chontapunta did more to integrate traditional practices in care encounters, but those at P.S. AMUPAKIN did more to actively challenge the unequal political structures around the integration of midwives.

Regardless of these distinctions, the involvement of midwives in any capacity was lost in the statistical measures used for the Intercultural Health Office. Each clinic reported all births to the district using a standardized obstetric spreadsheet. This data included the patients' ethnicity, whether or not they had a birth companion, and in which position they gave birth[47]. This information was then compiled by the Zonal Director of Health Promotion (and Intercultural Health) into the seven reporting criteria detailed in Chapter 3 (Table 4). At the time of research, the criteria of necessary PLPPI equipment and patient satisfaction were not being collected in the health district. Thus, the evaluative measures of whether or not births were considered "intercultural" were exclusively based on two problematic assumptions.

For one, the standards assume that any non-lithotomy position was chosen by the patient. However, as I have detailed, in some clinics the position was chosen by the biomedical providers, while in others it was more likely to have been chosen by midwives. Furthermore, this active provider role of midwives at both Chontapunta and P.S. AMUPAKIN is not included in any of the collected data, and is only reported as a "companion" in aggregate with family members, neighbors, etc. who may accompany a woman. Notably, even the district administrators were unaware of the informal partnership with the midwife at Chontapunta. Therefore, despite actions on the behalf of biomedical providers and district administrators to actively incorporate traditional practitioners in care, that more radical approach was essentially lost in the data. Since these data were the primary value reported to the MSP and the public, they ultimately reified PLPPI birth as an exclusively biomedical practice.

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[47] The provided options included: squatting, kneeling, side-lying, sitting, standing, and lithotomy position. Note, these do not account for use of any supportive equipment, whether traditional or not, such as suspended cords or wall bars.

Notably, all the biomedical professionals I interviewed (except one gynecologist) felt that formally incorporating midwives as part of the birth care team would be extremely beneficial for patients. Some felt it would provide more practical expertise to the team, especially in regards to the skills required for free-position birth. Others noted that midwives are also more focused on maintaining patient comfort throughout the labor process. In addition, several professionals noted that midwives' ability to reposition babies could further reduce c-section rates. However, they felt that in communities this practice posed risks of detaching the placenta or wrapping the cord, but in conjunction with fetal monitoring and risk screening it could become a safe and standard practice to compliment biomedical checkups.

They felt these intercultural partnerships required more structured relationships than what existed in the pilot Intercultural birth projects. For one, (more common amongst "cosmetic" proponents) these midwives needed to be certified and officially recognized staff of the MSP. They felt this would clarify issues of liability, strengthen relationships between providers, and establish patient trust. Second, they felt midwives should be paid for their work. For more cosmetic proponents, this was often phrased as "everyone needs to eat" or "all work should be paid". This pay would also eliminate the problematic proposal of the APKAM guide, where midwives and their patients would arrange pay amongst themselves. As several providers pointed out, that situation went against laws for free healthcare which could discourage women from seeking care where midwives were present. For more radical proponents, it was also a matter of recognizing their specialized experience and contributions to women's health:

> "We shouldn't just use them to raise our standards and say, 'I'm doing this' and not give them recognition. Like if our intercultural births increase, I get all the credit. We have to give them an economic recognition, because they have to live. And if we keep capturing more and more women to give birth here, what are they going to live off of?"- Dr. Sisa, MSP Rural-Year Physician

> “How can they do this type of birth with midwives, earn al those awards, and not pay them? The MSP is causing problems and playing innocent, you know? And now training doctors to do it themselves, that’s a theft in that case.” -Dr. Alberto, Private Hospital Physician

For these professionals in particular, the new policies for PLPPI threatened rather than supported traditional midwifery. One obstetrician, who had experience at both AMUPAKIN and the Otavalo hospital, summarized it as, “just when the model should be getting better, it’s getting worse.” For these providers, PLPPI was much needed, but the biopolitical agendas surrounding it and strained relationships with community midwives ultimately co-opted traditional models of care so they could be practiced by biomedical professionals and apply towards inherently biomedical measures of *Buen Vivir*.

4.2.2.3 When is Intercultural Health Real?

Despite the ubiquity of the medicinal gardens and the promotion of the recently implemented PLPPI rooms, community members and biomedical providers were generally unaware of Intercultural Health as a public health policy. For community members and biomedical patients, only a small minority were aware of the gardens or training/promotion of traditional practitioners. The programs that were known, were the older pilot projects integrating midwives with MSP clinics at AMUPAKIN and the health center in Loreto, Orellana Province[48]. None of the women I interviewed were aware of the availability of PLPPI in local MSP clinics.

Likewise, many of the MSP providers (with the exception of district administrators) were unfamiliar with the initiatives taking place in their own district. Both providers and administrators

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[48] The health center in Loreto was built in 2011 in partnership with the County Health Comission, which is unique to Loreto. The commission operates under its own budget and coordinates/supports care between the MSP, NGOs, and local indigenous organizations- including the Midwive’s Association. The health center includes a room for the dedicated use of the midwives, including for managing births. As the MSP refused to pay remunerations, the commission paid the 16 participating midwives $23/month if they completed their required shifts (CCSL 2016).

felt this was due to the limited 3 day orientation for rural-year physicians. In those 3 days the new providers had to be trained in all of the targeted health campaigns and their reporting requirements. As such, minimal time was dedicated to training in intercultural principles or initiatives. This likely had a significant influence on providers' interpretations of Interculturality as respectful care, since many of the campaigns emphasized care with *calidad y calidez.* This also meant that the only providers who knew PLPPI services were available worked in centers where it was being implemented. Providers at P.S. AMUPAKIN assumed all of the PLPPI clinics were partnered with a midwives' association. In contrast, the hospital gynecologists and providers at non-PLPPI clinics assumed the hospital (which only offered lithotomy position births) was the only option for institutional birth care.

Administrators, providers, and community members alike felt the absence of PLPPI care at the hospital was a considerable oversight. The most fundamental issue was that the hospital managed roughly 70% of all live births in the province (INEC 2010). Even if providers knew about the PLPPI clinics, their remote locations dissuaded women from other communities to go there for care. This meant that in practice, only 1% of births in the local MSP district during the research period were at locations offering PLPPI. Even if the PLPPI centers met their required quotas, this figure would only reach 12% of all institutional births[49]. While this would help decongest the hospital, it still meant that PLPPI was not a realistic option for the majority of women giving birth through the MSP in Napo Province.

Despite the lack of PLPPI at the hospital, multiple MSP campaigns required biomedical professionals to raise community awareness about their rights to an intercultural birth. For

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[49] Calculated from obstetric data provided by the District and Zonal Health offices, 2016.

example, the plan to reduce maternal mortality requires all pregnant women to complete a birth plan (see Figure 4). As part of the requirements, all doctors had to tell women about the benefits of the different birth positions, even though those positions were not allowed for hospital births. The doctors I interviewed noted they either had not given the section much thought, or thought it may have been related to home births. Since the majority of them received no training about the various positions, they relied on brief descriptions of the benefits they gleaned from policy documents and meetings with administrators. Although almost none of the community members I interviewed were aware of PLPPI policies, when given a description they were in unanimous support. Both men and women noted the approach provided much needed changes that would significantly improve women's birth experience compared to the loneliness, lack of support, and lack of privacy they felt characterized hospital births (see also Chapter 5). However, patients and

PLAN DE PARTO

Si decides dar a luz en el hospital, debes conocer:

A. ¿Quién te va a acompañar y cómo vas a ir al hospital para el parto?

....

B. ¿Quién cuidará de tus cosas y tus hijos cuando estes en el hospital?

....

Si decides dar a luz en la casa:

A. ¿Tienes una partera o persona capacitada para atender el parto y al bebé?.

....

B. ¿Tienes el plan para llevar al bebé al cento de salud u organizar la visita domiciliaria al segundo día de nacido?.

....

C. ¿Tienes preparado un plan para transporte y a quién llamar en caso de emergencia?.

....

Debes tener listo para llevar al hospital o para dar a luz en la casa:

a. Ropa y útiles de aseo para la madre.
b. Ropa y útiles de aseo para el bebé.
c. Dinero previsto para gastos de movilización e imprevistos.

Decide cómo dar a luz

De cuclillas ☐ Sentada ☐ Arrodillada ☐
De costado ☐ En posición horizontal ☐
Otro: ....

Es derecho del bebé:

1. *Tener contacto inmediato e ininterrumpido piel con piel con la madre.*
2. *Lactar en la primera hora de vida.*
3. *Que el cordón umbilical no sea pinzado antes de que deje de latir.*
4. *Permanecer junto a la madre durante su estancia en la unidad de salud.*

Decide How to Give Birth:
☐ Squatting
☐ Seated
☐ Kneeling
☐ On Side
☐ On Back
☐ Other

Figure 4. Mandatory Birth Plan Form

more radical proponents of intercultural health felt the lack of PLPPI in the hospital also represented a false promise in the affirmative biopolitical discourses of the state:

> "Hopefully they make it real and not just for promotion. They should let the baby's father join the birth like they should according to the law, but they've never allowed it at the hospital." – Érika, Community Member

> "We all have a right to good care, so it would be good for the patient to choose how she wants to be seen. If a woman is obliged to go the hospital but doesn't want to give birth like that, it's like we're forgetting her rights." – Klever, MSP TAPS

As Klever and Érika note, the promise of more inclusive policies is empty unless it actually happens in practice. In this case, women's choice to give birth in the hospital contradicted their supposed rights to an intercultural birth. Although the MSP was promoting the rights of women and the PLPPI clinic services, there was no real way for women to access those rights.

Ultimately, amongst healthcare providers there was disagreement about whether or not Interculturality in health was being achieved through the existing policies:

> "Yes, we're doing it because all of our processes are the same for all the patients. The care is provided with respect, respecting their culture, respecting their beliefs." – Dr. Paula, MSP Hospital Gynecologist

> "Here, intercultural health doesn't exist. Because for example, no matter what public health cures with medicine, and the culture here is accustomed to cure with plants. So there isn't intercultural health. Like the medicinal gardens, what was the purpose? They asked for the program to just be done, but not with the objective that it was basically implemented with" – Dr. Luisa, MSP Rural-Year Physician

> "Its like folklore dance. Like you're going to dress and dance like an indigenous person. I think there should be more indigenous professionals or more interaction with indigenous leaders because they're the ones who know the most about ancestral medicine." -Dr. Sisa, MSP Rural-Year Physician,

For biomedical professionals employing more cosmetic forms, Intercultural Health was achieved as long as patients were all treated with the same respect. However, those like Dr. Luisa and Dr. Sisa who employed more radical forms felt the continued separation of biomedical and traditional practitioners meant that intercultural health was not being achieved. For them, the ultimate goal would be institutionalized medical pluralism, where traditional practitioners such as midwives and *yachaks* would have their own consult rooms within MSP clinics. In the end, they felt the current Intercultural Health policies were a cosmetic smokescreen that used indigenous medicine as propaganda but ignored the structural inequities created by biomedical hegemony in the MSP.

Despite these critiques, even biomedical professionals who held more radical visions of Intercultural Health felt the current policies were an important step in the right direction:

> "Now they're updating everything saying a woman has the right to give birth how she wants. That's really recent, so we'll see what happens in a few years after they strengthen those processes." – Lic. Fiorella, MSP Rural-Year Nurse

> "I feel like the laws are still lacking, because a lot of people are applying them because they have to, not because they agree with that knowledge and respect it. But, without these policies health professionals could just say, 'no only occidental medicine'. But since its a public law or policy of the state they respect it a little more, they have to follow it ." - Dr. Sisa, MSP Rural-Year Physician

As Nurse Fiorella and all of the district administrators noted, the large-scale implementation of Intercultural Health policies was just beginning, and there were many kinks that still needed to be worked out. Hospitals and clinics still needed to be equipped, providers still needed to be trained, and resistant minds still needed to be convinced that Interculturality in health was important. As I heard many times, "we're getting there little by little". As Dr. Sisa reflects, the biopolitical processes meant to evaluate and enforce that process may be inadequate, but their existence was necessary to creating the fundamental cultural and structural shifts promised by Interculturality and *Buen Vivir*.

4.2.3 Subjectivities of Biomedical Providers

The conflicting agendas and limited support behind MSP policies created challenges that local biomedical healthcare providers found difficult to manage. This was particularly true of rural-year and contract providers who felt shocked and dismayed by the realities of life and work in the Amazon. Many of them had never before witnessed the extreme poverty common in many rural communities, with large families living in small homes with no access to safe drinking water. Likewise, their experiences in urban medical systems left the unprepared for the lack of necessary equipment, medications, and utilities in MSP clinics. All of the local service providers commented on the personal sacrifice of working in the MSP, having to utilize their own vehicles or regularly collect money amongst staff in order to pay for transportation for the required medical brigades. For many, they felt the shift in government discourse and biopolitical surveillance of local health services placed excessive pressure on doctors to achieve health outcomes despite significant barriers to health in communities. Discussing the outreach campaign for childhood malnutrition, Dr. Esteban noted:

> "There's a chain of causes that we can't only put health professionals to be in charge of. To say- 'here, these kids are malnourished- you do something', without taking into account norms or strategies that could be put in place in the local governments. In all of Napo, even though there's running water, none of it is potable. So all of those things like parasitosis are just going to happen, from things that don't depend on health professionals."

For providers and administrators, the compliance mechanisms such as the monthly reports and accreditation requirements created pressure on them to personally ensure that the Good Life was achieved. However, they felt this approach also obfuscated more important priorities in infrastructure, education, and poverty reduction that would make bigger and more lasting impacts.

Some providers, especially those who employed more cosmetic approaches, felt the lack of support combined with the pressure to respect patients' rights signaled a growing lack of respect for medical professionals:

> "We don't have any support as public servants, now everything is all about patients' rights. But we also have rights, and it's not good that we treat them with respect when they can treat us badly. This respect in all settings, in all its meanings has dropped to the floor." – Dr. Martin, MSP Rural-Year Dentist

For these providers, the ultimate responsibility for achieving *Buen Vivir* lay on patients. However, the policies surrounded local healthcare placed the burden on providers. They felt the rights'-based discourses and policies were fostering a sense of entitlement amongst patients who were not always fulfilling their roles as ideal citizens.

Furthermore, health providers felt their own professional precarity dissuaded them from supporting more radical approaches to Interculturality. All but two of the providers I interviewed (both hospital gynecologists) were working under one year contracts or completing their rural year of service. Many of them expressed fears of losing their positions or ability to practice medicine if they did not comply with the priorities of the district administrators:

> "I have to complete my rural year to get my license. So it's on me to adapt and please the people at the top. If not, they can end my rural year. I can't lose my rural year no matter what, even if they fire me it's the same issue." – Dr. Luisa, MSP Rural-Year Physician

For some providers, this obligations meant focusing their limited time and energy on the priority health campaigns (and their extensive reporting requirements) versus the less monitored initiatives in Intercultural Health. For providers working in PLPPI clinics, such as Dr. Luisa, this also meant increased pressure to mitigate risks. For her and the other providers at P.S. AMUPAKIN, this pressure was not only about risk of obstetric emergencies, but also about the legal negotiations between the midwives' association and the MSP. Rather than be seen as politically aligned with the midwives, the providers preferred to maintain separation between the two organizations.

Achieving the new biopolitical standards of *Buen Vivir* and Intercultural Health were understood to be inherently political acts. As several providers noted, district administrators were often preoccupied with achieving statistical goals because achieving targets was a way of their positions. Administrative positions had a high turnover rate, often linked with changes to changes in administrators higher up the MSP hierarchy. In informal conversations, I heard many rumors about these changes being linked to party politics of Alianza PAIS, including one that some administrators were requiring professionals to officially register for the party in order to keep their job placements. Correa's often fraught relationship with indigenous organizations made partnerships with associations such as AMUPAKIN especially challenging to maintain. For some directors, these relationships were a critical component for achieving the affirmative biopolitics of *Buen Vivir*. For others, distrust of indigenous groups encouraged ended outside affiliations in preference of strategies completely under the control of the MSP, such as was the case with the TAPS and PLPPI births. Nevertheless, the constant turn-over of administrators brought with it a constant fluctuation in the support of IH initiatives. The district director present at the beginning of the research period was uninterested in IH programs, while the new director supported them whole-heartedly. However, his attempts to formalize the relationship with the midwives' association with the financial backing of local governments was abandoned when he replaced after only one year in office.

Indigenous professionals, in contrast, had to negotiate their own role in the new biopolitical agendas of the state with concerns over their impacts on indigenous culture and self-determination. As indicated in earlier quotes, Dr. Sisa in particular was concerned about how the PLPPI births she performed could actually help wipe out traditional midwifery. While she paid the local midwive for her assistance in deliveries a way to reduce complications, it was also out of a sense of cultural duty:

> "The MSP uses midwives and yachaks as a screen, but they don't give them anything real. That's folklore, I don't identitfy with it. It's not my culture, I didn't grow up that way. When I see someone actually trying to recuperate that knowledge, its like, 'yes, that's ours." – Dr. Sisa, MSP Rural-Year Physician

Likewise, the TAPS commented on how they felt the need to continue to support traditional medicines by promoting local practices and healers, but that the policies gave them little opportunity to do so. In addition, they had to balance their duties of capturing patients with the communities' wariness over the increased surveillance. The TAPS however, did not question their own role in funneling care to the MSP, but instead critiqued the ways the policies kept traditional medicines from being equally viable options for care.

4.3 Discussion

In this chapter I have examined how Intercultural Health policies are implemented in local public health services. Specifically, I have outlined the ways biomedical professionals enact and interpret the biopolitics of *Buen Vivir* and Interculturality as they are applied to the transformation of primary health care. Through their roles as primary care providers and data collectors, biomedical staff are the primary agents of affirmative biopolitics on the ground. Likewise, roles of district administrators in interpreting and operationalizing IH policies in local contexts significantly shapes the ways in which new standards are supported or undermined. Although biomedical professionals support IH initiatives, they have varied expectations of what their implementation should achieve. Some providers felt that respecting patients' different beliefs and needs was sufficient. Others criticized that approach as cosmetic Interculturality, and instead sought more meaningful and systematic integration of traditional medicine practitioners. Regardless of their opinions, providers felt the new policies did little to support them in making Interculturality real in practice, and in some ways even prevented meaningful implementation.

On one hand, the priority biopolitical surveillance of the healthcare system often conflicted with Intercultural Health initiatives that impacted patient utilization and participation in less predictable ways. On the other hand, the methods used to evaluate and enforce intercultural initiatives themselves reinforced the power of the MSP while minimizing recognition of contributions by midwives and other traditional practitioners. Finally, the tenuous political environment and precarious position of most MSP personnel limited their ability to challenge these biopolitical structures.

These experiences and perspectives of local health services are in many ways the direct results of the decisions made by the policy makers discussed in the previous chapter. Despite the presence of Holistic discourses of Interculturality, the methods of implementing and evaluating Intercultural Health clearly reflected the Reductionist Discourse present in the national IH office in the MSP. Unlike policy makers, however, local health professionals were more concerned with the practical implications of these biopolitical agendas on their work than with more theoretical discussions of rights to difference versus rights to choice. Although policy makers felt marginalized by other political agendas in the MSP, local biomedical professionals found themselves in the position of actively negotiating competing biopolitical agendas as they attempted to fulfill their roles as providers of health and collectors of data. Given this role, and their general position of professional precarity, they felt they had limited agency or desire to effect change towards more radical or Holistic visions of Interculturality. Furthermore, for more radical proponents, their position within the hierarchy of biomedical practice underscored for them the need to transform the structure of the MSP towards formal institutionalized medical pluralism. For them, the risk of changing the meaning and practice of traditional medicines in this setting was preferable to the co-optation and eventual elimination of traditional practices they felt was occurring under the current policies.

Because of these differences, the practice of Intercultural Health in local biomedical services presents a slightly different perspective of the 4 Components of Affirmative Biopolitics. Like the political stakeholders influencing policy, biomedical professionals recognized the incorporation of Interculturality in health as means to welcome a **plurality of lifeways** within local health services. The most common understanding was that required respectful care for all patients, regardless of their ethnicity or medical itineraries. However, the **political and structural adjustments** that were implemented did little to change the assumption that *Buen Vivir* was only truly achievable through biomedicine. This was clear in the totality of biopolitical mechanisms of local health care, where the affirmative goal of achieving *Buen Vivir* through universal health for all was reduced to a political discourse of universal access to quality care, and again distilled to mean a universal utilization of newly modified biomedical services. At this level, initiatives towards **participatory governance** were beginning to show an impact on reinforcing more affirmative and inclusive forms of care, especially through satisfaction surveys and formal complaint processes. However, biomedical professionals felt their ability to enact change was limited by their own roles in the MSP. Although some providers and administrators attempted to challenge the biomedical hegemony of the system, they typically did not see themselves as part of broader **networks of change** that could have widespread or lasting impact.

These findings are similar to those seen in other studies of Intercultural Health and culturally appropriate care. As several studies have noted, indigenous populations and their culture are often blamed for assumed “noncompliance” with biomedical authority and hegemonic standards of wellbeing (Tait 2000, Huayhua 2010, Smith-Oka 2013). Likewise, Duran has critiqued biomedicine’s emphasis on data collection over holistic healing as an inherently oppressive practice (Duran 2006). Others have noted that culturally focused interventions such as Intercultural Health can actually encourage processes of Othering and polarized relationships of “us” vs “them,” particularly by reinforcing a “politics of the gap” (although not always with negative connotations) (Kirkham 2003, Boccara 2007, Kowal 2008).

These processes are clearly visible in biomedical professionals discussions of community participation and patient compliance, where a line is drawn between the clinic seen to quite literally **provide** health, and the communities who are wary of what that care could mean. While intercultural initiatives attempted to recognize the role of traditional medicines in achieving health, the biopolitical structures around them did not include any meaningful measures of those contributions (such as number of women referred by traditional practitioners, or PLPPI births accompanied or managed by midwives). Although meeting indicators of IH compliance took precedence over more radical forms of integration and participation, IH policies have created new opportunities through which affirmative changes can become more widely accepted by biomedical staff. This includes accreditation standards and the upscaling of PLPPI. As was the case in Chontapunta, this enabled more radical relationships to be accepted rather than sanctioned.

As noted in other chapters, the biopoliticization of Interculturality necessarily draws boundaries of control that go against its radical origins. However, it has reinforced an iterative process of change that has made a noticeable impact on care and the relationships between patients and biomedical providers. The importance of this shift should not be understated, particularly in the context of Intercultural Health policies in neighboring Latin American countries. In Peru, for example, Intercultural Birth programs obfuscated policies that coerced women to birth in biomedical institutions, and ignored widespread forms of discrimination and obstetric violence (Guerra-Reyes 2019). In Bolivia, IH policies created new state controls over the authenticity of traditional practitioners, while doing little to address the severe inequities of access to biomedical services for rural and indigenous communities (Ramírez Hita 2014). Likewise, policies in Chile and other countries are exclusively limited to indigenous territories, while the accreditation standards made (albeit minimal) practices of Intercultural Health required of all primary care clinics nationwide (Aguirre Fonseca 2007, Bolados García 2012).

In addition, the emphasis on measurements of biomedical utilization and obligations echo theories of biocitizenship around sanitary citizenship and self-care. Emphasis on traditional practitioners and TAPS as community liaisons funneling patients to biomedical services may indeed be "making indigenous people participants in their own modernization" (Boccara 2007). However, as the experiences of local health professionals demonstrate, the affirmative biopolitics of Intercultural Health did serve to challenge colonial notions of sanitary citizenship that reinforced a singular model of healthy living and responsibility, at least to a small but noticeable degree. Nevertheless, the limited forms of implementation, such as gardens and vertical birth, represent the forms of "sanitized alterity" approved by the state biopolitical apparatus (see Kowal 2008). As Boccara notes of Intercultural Health programs in Chile, this process encourages the creation of "new" traditions, ones that are "functional, reconstructed, reinvented, and repurposed" (2007, p. 202). As the more radical proponents of IH noted, these forms prioritized symbolically visual methods of intercultural practice while doing little to question the hegemony of biomedicine. The principle questions of these policies, then, is whether these processes of revitalization/reconstruction benefit the communities who originated them.

In the case of biomedical health services, the answer is complex. Indigenous community members acknowledged significant changes in the treatment they received from biomedical professionals. Likewise, nearly all providers and community members celebrated the implementation of birth reforms. However, the impacts on traditional practitioners, and traditional ideologies of health more generally, were a continued point of conflict. In the following chapter, I examine the experiences and perspectives of traditional practitioners as they negotiate their roles in the new healthcare system.

5.0 Chapter 5: Perspectives of Traditional Medical Practitioners

In this chapter, I analyze how practitioners of traditional Kichwa medicine (*Sacha Ambi* [forest medicine]*)* negotiate their roles in these policies and their impact on revitalizing indigenous medicines. In their roles as cultural specialists, traditional medical practitioners are considered guardians of the customs Intercultural Health policies aim to revitalize and promote as part of the plurality of lifeways recognized in *Buen Vivir*. While policy makers (Chapter 3) and local healthcare professionals (Chapter 4) are primarily concerned with the operationalization of Interculturality in biomedical services, traditional practitioners are more concerned with maintaining health and cultural values in their own communities. Consequently, they find themselves within a point of friction between conflicting expectations of the Good Life, Interculturality, and how they should be achieved.

In the first section, I outline the roles of traditional practitioners in Napo Runa communities, especially as they relate to pregnancy and birth. In the second section, I examine how traditional practitioners understand and engage with the affirmative biopolitics of Interculturality and *Buen Vivir* in their relationships with the MSP and their communities. Most importantly, I argue the frictions between traditional practitioners and the MSP are the result of conflicts over the definitions and values inherent to the affirmative biopolitics of Interculturality and *Buen Vivir*. Despite supporting goals of increased access to biomedical care and revitalization of indigenous culture, traditional practitioners are critical of the ways the policies undermine their value as medical professionals in their own right. Through their experiences, we can see how the marginalization of more radical/holistic approaches to Interculturality amongst MSP policy makers and healthcare providers can undermine cultural revitalization efforts in Napo Runa communities.

5.1 Shamanism and Midwifery in the Times of Buen Vivir

Napo Runa communities have faced an ever-accelerating shift in lifestyle characterized by integration in the (inter)national market economy, living in permanent settlements, and utilizing formal social services in education and biomedicine. While these processes of change began with the establishment of Josephine missions, they firmly took hold in the 1960s with the influx of infrastructure and outside settlers (*colonos)* spurred by the discovery of large oil deposits in the Amazon. These processes of change have only increased with the expansion of state infrastructure in the region brought on by the neo-socialism of the Correa Administration. The rapid pace of state development in recent years has created a sharp intergenerational divide within Napo Runa families and communities. In large part, the elderly were raised with subsistence agriculture and meaningful relationships with the spirits of the forests and rivers. In contrast, the lives of their grandchildren are defined by their frequent interactions with institutions[50] and cultural outsiders (both mestizos and foreigners) in the urban centers. Despite a long history of co-opting and adapting external practices and knowledge for the benefit of their communities, the loss of traditional Runa values and knowledge was a constant topic of commentary by the young and old alike.

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[50] The most important and ubiquitous institutions by far are the high schools, which are concentrated around Archidona and Tena. By the time of research, the expansion of public education services in Runa communities had focused on expanding preschool and elementary school services.

In everyday conversations and even political speeches, it was common to hear Napo Runa draw a distinction between the often nostalgic values of *Ruku Kawsay* [old way of life] and the ways younger generations are increasingly enacting mestizo lifestyles and values (*mishu tukurina* [becoming mestizos]). In this section, I will outline the roles of midwives and *yachaks* [shamans] in both the "old way of life" and the new way of life encouraged by the policies of *Buen Vivir*. In doing so, I will attempt to remain true to the cultural dichotomy discursively employed by Napo Runa while also demonstrating the complex ways they continue to negotiate how to achieve a Good Life in an ever-changing world. As other scholars of Latin America have argued, it is critical to understand how indigenous ontologies and constructions of alterity are continually evolving and responding to shifting access to resources and both internal and external relationships of power (Bessire and Bond 2014, Erazo and Jarrett 2018).

In traditional Runa medical ideologies, physical health is the result of several processes that promote strength and general well-being. I was made aware of these processes through everyday interactions and interviews with many Napo Runa, especially the midwives of AMUPAKIN.[51] As described in Chapter 1, the social circulation of vital substances, particularly food, *aswa* [manioc beer], and *samai* [vital essence, lit. breath] is at the core of *alli kawsana* [living well]. This circulation directly impacts physical health in several ways. First, the expected exchange of goods between community members, such as women's *aswa* and garden products with men's meat and fish, redistributes goods for a well-balanced diet. Second, the exchange

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[51] My experiences corroborate those of other Napo Runa scholars. For a more detailed discussion of how well-being is reproduced and maintained in modern-day Runa communities see Bridges Bridges, N. C. (2017). The Therapeutic Ecologies of Napo Runa Wellbeing, University of Pittsburgh. and Uzendoski Uzendoski, M. (2005). "The Napo Runa of Amazonian Ecuador." Interpretations of culture in the new millennium: xii, 198 p..

includes both the base ingredients and prepared products (teas, salves, etc.) used to restore health in the case of illness or injury.

In addition, many other activities essential to *Ruku Kawsay* are centered around building strength (*sinzhiyachin)* in all senses of the word: physical, spiritual, and moral. This includes bathing in cold rivers, rising before dawn to drink guayusa tea, and eating food from the forest and rivers (in contrast to *llakta mikuna* [city food]).[52] At various points of a person's life cycle they may be particularly susceptible to poor health and the detrimental intervention of natural spirits or *aya*. This includes early childhood, pregnancy, illness, and when encountering *aya* (such as during shamanic rituals). During these times, extra precautions are taken to increase a person's strength through behavioral and dietary taboos called *sasina* [ritual diets]. Just before and after birth, for example, a mother should only eat Kichwa food, such as free-range chickens. When gathering manioc in her garden, she should carefully place it upright in her basket *(dirichu* [straight]*)* so that her baby will also be in the proper position for birth (also described as *dirichu).* These *sasina* also apply to new fathers, who are expected to abstain from sport, sexual relations, and certain foods in order to strengthen their child's *samai* and ensure they develop properly (see also Uzendoski 2005). Likewise, *yachaks* must follow *sasina* before performing rituals to give them strength and power when meeting with *aya* during shamanic visions. These *sasina* are also seen as necessary for *sacha ambi* to be fully effective when taken, both in the case of herbal remedies and entheogenic substances such as *ayahuasca* and *wanduj* [brugmansia insignis].

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[52] Uzendoski (2005), describes the use of stinging nettles and hot peppers primarily as forms of punishment with secondary health benefits. While some of the younger Runa I spent time with agreed with that perspective, the older Runa I knew strongly contested it. For them, placing tobacco or hot pepper juice (*tubacu churana* and *uchu churana*) was an important part of

These ideologies of well-being, illness prevention and the social relationships necessary to produce them are reinforced through public processes of *kamachina* [to give advice, to scold]. As I witnessed on several occasions, parents, kin, elders, and *markamamayayakuna* [godmothers and godfathers] tell the younger generation how to live well: to not eat city food, to drink guayusa and aswa, to not drink too much alcohol, to do well in school, and to fulfill their obligations to their social relations. These "lectures" are central methods of teaching Runa values. All important events in Runa life such as weddings and baptisms feature moments of *kamachina* where kin and godparents advise young people on how to achieve *alli kawsana*.

However, *kamachina* is also about correcting improper and unhealthy behavior, where lectures may be combined with forms of discipline including swatting with stinging nettles, or placing the juice of wild tobacco or hot peppers in the nose, mouth, or eyes. Many of the older Runa I spent time with were upset by how these practices have been increasingly critiqued (especially by school teachers and other cultural outsiders) as physical abuse. In contrast, they saw them as important ways through which parents enact love for their children by making them strong. For one, the advice and discipline set them on the right path for a good life. But also, the medicinal and unpleasant properties of the plants (stinging, burning, bitterness) are seen to fortify the recipient's physical body and *samai*. Due to their cultural importance, practices such as *uchu churana* have become an important part of cultural revitalization activities, including festivals and bilingual radio programs (see also Ennis 2019). In the following section, I will address how the members of AMUPAKIN employ the *uchu churana* as part of their efforts to maintain authentic Runa practices and the values behind them.

When accidents and ailments do occur, there are many forms of care available within Napo Runa medical traditions. Household or other community members may prepare treatments from garden or forest plants. Those who have particular skill in a certain form of diagnosis or treatment are referred to as *pajuyuj* [lit.. person with power]. There are many types of *paju*, and they can only be obtained from other people or spirits who already have that skill. Through the collection of various *paju* a person can specialize in ailments or treatments including herbal remedies, massage, or sweeping (*pichana)* to strengthen a person's *samai.*

Midwives *(achimamaguna or achiyayaguna*[53] in the Archidona dialect), are one such specialty. Following the old ways, a traditional *achimama* is an important figure from pregnancy through the post-partum period. During pregnancy, they give massages, reposition the fetus (*volteyachin, dirichuyachin),* treat UTIs, and advise mothers on the *sasinas* they should perform to ensure proper fetal development and an uncomplicated birth. Once a woman is in labor, they prepare several herbal infusions to be given at different stages of delivery: one to help the waters break and speed up delivery, another to give the mother strength during continued labor, and another to prevent post-partum hemorrhage. During the first stage of labor (dilation) they provide massages, and guide the woman's close relatives on how to comfort and support her, including walking to speed dilation and various positions to alleviate the pain of contractions. They also use several methods to track the progress of dilation, including timing contractions, and changes in the mother's energy level and temperature.

In the second stage of labor (active pushing), the midwife assists the mother into a comfortable birthing position, typically kneeling on the floor with the mother's hands or shoulders supported by a suspended rope (see Figure 5). The midwife shows the woman's family how to physically support her in this position, and blows on her head to give her more *samai* for pushing.

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[53] The English term "midwife" is gender neutral (lit. with woman), while *achimama* and *achiyaya* are gender specific. In my research I encountered both male and female midwives. However, the overwhelming majority of midwives in Runa communities are women, and as such they are regularly referred to in the general sense as women.

For the final expulsion, they give the mother a small amount of food to give her strength and also to prevent fainting. They catch the baby as it is born, and wait to cut the umbilical cord until the placenta (*wawa wasi, wawa mama)* is delivered. The midwife then guides the family on how to care for the mother as she bathes the baby with medicinal plants to give it strength. In the immediate post-partum period the midwife advises the woman and her family on proper diet and *sasina,* tips for milk production and breastfeeding, and how to properly swaddle a baby using a *chumbi* (patterned, woven straps). In the extended post-partum period, Runa midwives provide massages and herbal remedies to help mothers heal and return to their normal physical state. This includes the practice of *encaderamiento,* where a midwife positions the uterus and pelvis, tightly binding them in place with a wide *chumbi* around the woman's hips.[54]

Figure 5. Demonstration of a Ruku Kawsay "Traditional" Birth

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[54] In the Sierra, the practice of *encaderamiento* is also a form of traditional birth control Mayta Zapata, D. R. and D. P. Vlaverde (2016). Principales Conocimientos, Actitudes y Prácticas que influyen el use to Anticonceptivos en la población Kichwa Otavalo. Especializacion en Medicina Familiar y Comunitaria, Pontifica Universidad Católica del Ecuador., but in my discussions with Napo midwives the primary purpose was to re-tighten the pelvis.

While all of these activities have practical implications in the physiology of maternal care, they are replete with deeper meaning and purpose within Kichwa ideologies of health. By ensuring the baby is *direchu* or "straight" in the womb and later in the swaddle, the midwife is also imparting a moral straightness and strength to an infant that is seen as both vulnerable and soft (*llullu* [also unripe]). The *chumbi* itself also serves to protect the infant and mother (in the case of *encaderamiento)* from spirits and *mal aire* (evil wind) during their time of weakness (see also Uzendoski 2005). The midwife's role in giving advice makes her an important source of *kamachina* related to the health of women, children, and young families. This role is often recognized by asking the midwife to be a godparent for the newborn, which solidifies this responsibility throughout the child's life. As the older midwives often joked, after delivering many babies they are "everybody's godmother," which likewise makes them a common source of *kamachina* for the community at large.

Yachaks [shamans] are likewise and important source of both health and guidance in Napo Runa communities. In drinking *ayawaska* or *wanduj* the shaman is able to see and converse with the spirits around him[55] who aid him in identifying the cause of an illness or injury and the best method of treating it. As such, a *Yachak*'s power is related to diversity of spirits he is familiar with (*riksina)* to call on for assistance, and the number of *paju* he has acquired to put treatments into practice. In addition, these spirits can also provide visions of the future. In my own research, several Runa women told me of how they would go to a *yachak* to learn the sex of their unborn child, when it would be born, and whether there would be complications. As with midwives, giving advice is a critical component to shamanic practice, and *yachaks* are often relied upon to meet with

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[55] As with midwives, both men and women can be *yachaks*. However, men are much more common. Women *yachaks* are thought to be more powerful, a designation that makes them especially targeted by witchcraft from other shamans that leads to illness or even death. This was often given as the reason why there are fewer women shamans.

the spirits and provide *kamachina* in a wide variety of issues including marital conflict, illness, and societal change.

In the Ecuadorian Amazon, *yachaks* are also central figures in the politics of Napo Runa communities. As other Amazonian scholars have noted, *yachaks* often foretell of and advise on looming changes to Runa life, including extractive industry (Whitten and Whitten 2008), and community tourism (Davidov 2010). In addition, they are able to develop intra and international networks as they travel broadly to become familiar with more *aya* and gain new *paju.* This role gained increased importance with the significant involvement of Amazonian *yachaks* in the indigenous movement of the 1990s and early 2000s (Uzendoski 2006, Davidov 2010, Whitten and Whitten 2015). In more recent years, *yachaks* have also contributed to critiques and protests against the *Buen Vivir* development plan and politics of Rafael Correa. In one instance, *yachaks* in one Amazonian community advised community members against enrolling in Conditional Cash Transfers over concerns they were being used coercively to expand oil drilling in indigenous communities (Rinehart and McGuire 2017).

Yachaks, however, are also controversial figures within Napo Runa communities. While they have the power to heal, they also have the power to harm. This can be accidental, if shaman is angry and his power escapes him (Uzendoski 2005). However, it can also be intentional where the *yachak* or his client target another person to cause them harm. This can be done in several ways, including enticing spirits to cause an accident or by sending *biruti* [spirit darts] that cause illness and even death. While this power to harm is often critiqued by Runa themselves, it is often described as part of the intrinsic forces of love and anger that reinforce proper behavior (Muratorio 1991, Whitten and Whitten 2008, Uzendoski and Calapucha-Tapuy 2012).

Despite the continued importance of *Ruku Kawsay* amongst Napo Runa communities and traditional medical practitioners, there is little effort or desire among either to maintain pure boundaries between *sacha ambi*, *llakta ambi,* and other forms of healing. As Bridges describes, Napo Runa purposefully employ "enmeshed therapeutic ecologies" that allow them to embrace markedly distinct methods in a continually evolving repertoire of Runa healthcare practices (2017). As will be discussed in the following sections, this was evident in the lives of the Napo Runa I interacted with, where aspects of biomedicine and *sacha ambi* were regularly used in various combinations to improve a person's health. In my own experiences with midwives and *yachaks*, skills and materials from other systems were often employed in combination with more quintessentially Runa practices. During births at AMUPAKIN, examples included the use of a birth chair in addition to the suspended rope, and the use of Pitocin to hasten labor[56] (Figure 6).

Figure 6. Contemporary Kichwa Birth at AMUPAKIN

As evidenced by Figures 1 and 2, many of the components of a "traditional" birth had changed for matters of convenience. For example, the symbolically important *carawaska* vine once used to

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[56] This practice was somewhat controversial amongst the midwives, as several preferred to only use traditional teas. When used, Pitocin was only administered by one of the doctors.

support the mother during delivery had widely been replaced with bedsheets, which were easier to obtain and keep clean.

These enmeshed therapeutic ecologies are lived and understood in complex ways. As other studies of medical pluralism have noted, practitioners and patients alike navigate multiple ideological and ontological perspectives at once, in processes described as medical "braided-ness," entanglements, and enmeshed ecologies (Mukharji 2016, Bridges 2017, Khalikova 2020). This was certainly the case in Napo, where disease etiology was often ascribed to both spiritual and biological agents. One clear example comes from a Runa midwife in her 50s, explaining why 7 of her 13 children died at young ages:

> "They died because back then my husband did a lot of shamanism. But I don't know, back then they also didn't vaccinate a lot. There weren't many doctors and there wasn't an obligation to go be treated by the doctors either." -Maruja, 50 years old, Community Midwife

In her description, she begins by explaining her children likely died as a result of witchcraft directed at her husband. However, she also recognizes the role viral disease and other biological causes may have played. Her final thought also underscores how the policies of *Buen Vivir* and the resulting changes to the healthcare system have impacted the enmeshed therapeutic ecologies in indigenous communities. As discussed in more detail in Chapter 4, the reforms have not only increased access to and awareness of biomedical approaches to health, but has also created obligations that those services be utilized.

For most Runa community members (including traditional practitioners), the obligations to utilize biomedical services were reinforced through frequent outreach talks and brigades at schools and, to a smaller degree, conditional cash transfers such as the *Bono de Desarrollo Humano* (BDH) [Human Development Voucher]. While the BDH existed before the Correa administration, it was dramatically expanded to achieve the *Buen Vivir* goals of reducing poverty and improving maternal and child health[57]. Through the program, female heads of households in extreme poverty[58] are given monthly cash transfers from $50 to $150 depending on the number of children in the family under 18 years of age. To receive the transfer, families must comply with a set of co-responsibilities in education and health services.

The co-responsibilities for health are meeting the recommended number checkups for pregnant women (5 minimum) and children (6 in the first year of life, 2 per year for children aged 1-5), as well as attending at least one educational talk on family planning for all family members of childbearing age (Martínez, Borja et al. 2017). Unlike other countries, the BDH did not make institutional birth a requirement for transfers (see Smith-Oka 2013, Guerra-Reyes 2019). Although Napo Province has relatively low coverage of its large population in extreme poverty, coverage was highest in the areas around Archidona and Tena, where my research was conducted (MIES 2013). The *Bono* was seen as a hallmark of the neo-socialist policies of the Correa administration, but had also become a point of contention as the economic crisis led to a significant reduction of eligible households in 2015 (Comercio 2018). While none of the Napo Runa I talked with challenged the co-responsibilities required of the *Bono,* many of them felt that achieving them increased families' financial precarity. In addition, the sudden removal of support was felt to be indicative of the ways *Buen Vivir* conflicted with *alli kawsana*, as I will discuss in the next section

The *Buen Vivir* reforms were visible in nearly every aspect of life in Napo. Communities were regularly engaged with biomedical providers via health brigades and public outreach events. Targeted campaigns for controlling mosquito populations (vectors for dengue, malaria and chikunguya), creating an obstetrical census, and vaccinating domestic animals against rabies also

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[57] Similar programs for the elderly and disabled were also expanded and created during the Correa Administration.
[58] Identified through a proxy means test measuring multidimensional poverty.

put community members in relatively frequent contact with professionals from the MSP. Traditional practitioners sometimes played a direct role in these campaigns, as members of community organizations or local health committees. As described in Chapter 4, this often put them in roles as formal liaisons between health centers and community members, with the expectation of disseminating biomedical health literacy and referring at-risk patients to the clinic.

The influence of *yachaks* and midwives in Napo Province has also changed considerably with the establishment of legally recognized associations in Napo. As Erazo and Jarret outline in their history of the politics of shamans in Archidona, the creation of indigenous community organizations in the 1970s established a tenuous relationship between newly powerful indigenous leaders and revered shamans, and even dissuaded community members from utilizing shamanic services in favor of newly established peasant insurance cooperatives (Erazo and Jarrett 2018). But, the growing influence of the indigenous rights movement, eco-and enthotourism, and increased interest in indigenous medical practitioners in the 1990s brought an influx of resources and support for *yachaks* and midwives in particular (see Chapter 3). This spurred the creation of formal associations of traditional medical practitioners, including the midwife association AMUPAKIN (est. 1998) and the *Consejo de Yachak Runa Amazónicos del Ecuador* (CYRAE, est. 1997)[59], an association of *yachaks* headquartered in Tena.

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[59] Formerly known as the *Asociación de Shamanes Indígenas de Napo* (ASHIN).

With this legal recognition, traditional practitioners who were members of the associations gained access to new networks of power and resources that continues to the present. First, it enabled direct partnerships between traditional practitioners and NGOs, including those that launched the influential pilot projects in Intercultural Health such as the Casa Para la Vida established by AMUPAKIN and the Red Cross. Second, both organizations were founded as members of the regional subsidiary of CONAIE, now named FOIN. This relationship has given association members entrée into regional and national politics. For example, members of CYRAE proposed integration of traditional practitioners within MSP facilities during the Constituent Assembles as part of the development of the TSSE plan to transform the healthcare system (Colonos 2017). During my own research, AMUPAKIN was asked to participate in several political events and rallies, including a luncheon with President Correa before he held a *sabatina* [weekly national address] in Tena.

Figure 7. AMUPAKIN and the Author with President Correa

The strength of these organizations was challenged to a degree by efforts of the Correa administration to regulate civil society. Executive Decrees 16 and 763, required Associations and other NGOs to submit substantial paperwork regarding the organizational structure, member information, and finances. The administration argued it was necessary for maintaining transparency and "achieving the first objective proposed in the *Buen Vivir* Plan for 2013-2017"(Comercio 2014). But many Ecuadorians viewed it is a way to control political rivals, including the environmental organization Pachamama that was dissolved under the law in 2013 (Comercio 2017). Members of AMUPAKIN shared these concerns, but had to comply in order to maintain their *factura*, an invoice number necessary for legal transactions and paying taxes. The often arduous requirements meant that AMUPAKIN and many other indigenous organizations I encountered in Napo often had lapsed *facturas*, which significantly impacted their ability to conduct business and establish partnerships with NGOs and local governments.

However, the reforms of the Correa administration also created space for traditional medical practitioners as agents of participatory democracy and the recognition of plural lifeways. In 2007, Correa established the Ministry of Culture[60], and dramatically increased state funding of cultural events and initiatives (Velástegui 2021). Through the Ministry of Culture, local governments, indigenous organizations and associations of traditional medical practitioners gained access to grants and loans for cultural revitalization projects. In Napo, this included support for cultural events such as the Jumandy Festival in Archidona (in which both CYRAE and AMUPAKIN were paid participants), and a Kichwa pottery course held at AMUPAKIN. In addition, processes and institutions created to foster democratic participation frequently included AMUPAKIN and CYRAE as representatives of the broader Kichwa community in Napo. This included the participation of the president of AMUPAKIN in courses of citizens' rights through the *Consejo de Participación Ciudadana y Control Social* (CPCCS, see Chapter 1). Likewise, CYRAE was part of a 2012 agreement between local governments and indigenous federations to

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[60] Notably, the Ministry of Culture was founded with a "Cultural Revolution" as its mission which featured the promotion of "decolonization" and a "new contemporary Ecuadorian identity" Roitman, K. and A. Oviedo (2017). "Mestizo racism in Ecuador." Ethnic and racial studies **40**(15): 2768-2786.

establish joint actions for Amazonian Kichwa communities, a process overseen by the Ministry of of Political Coordination (Independiente 2012).

In the following section, I will discuss further how government policies for achieving *Buen Vivir* and Interculturality in health have shaped the ways traditional medicine practitioners both practice their craft and work to revalue and revitalize Napo Runa culture. As I have touched upon here, policies both within and outside of the MSP have created points of friction where the cultural (and political) value of traditional medicines are contrasted with their value as medical practice. In addition, I examine how Intercultural Health policies and their implementation often misrepresent and conflict with the enmeshed therapeutic ecologies of indigenous communities. Just as policy makers and indigenous activists wrestled with these conflicts in the formation of IH policies (Chapter 3), traditional practitioners do so in very different contexts and positions of power.

5.2 Enacting Intercultural Health with Traditional Practitioners

Through the influence of indigenous organizations, the national politics of *Buen Vivir* during the Correa administration contained an explicit obligation to acknowledge plurinationality and practice Interculturality. These policies were meant to legitimize multiple lifeways in the process of achieving a good life for all Ecuadorians. In the realm of healthcare, policies for Intercultural health have aimed to promote and valorize traditional indigenous medicines. As discussed in the previous chapters, the design and implementation of Intercultural Health policies have both obligated and obscured partnerships between the MSP and traditional practitioners.

Nevertheless, the policies have reified the role of traditional practitioners as powerful actors in their communities and as guardians of indigenous culture.

In the two preceding chapters, I examined how policy makers/activists and biomedical professionals negotiate their roles and conflicting values during the design and implementation of Intercultural Health policies. In those roles, they have a direct relationship with the affirmative biopolitics of healthcare reform. However, as I will demonstrate in this chapter, traditional practitioners' experiences of those same biopolitics are often more complex and multidimensional. First, they are considered allies in efforts to achieve the biopolitical goals of *Buen Vivir*, especially the reduction of maternal and neonatal mortality. However, there is conflict over whether that role should be as community liaisons or as agents of health in their own right. Second, their increased market integration and simultaneous lack of economic opportunity in their own communities make them part of the target populations for those same programs. Finally, the purposeful display of alterity by some traditional practitioners has reified their role as cultural symbol. While this can strengthen Runa efforts to reclaim the "old ways" in new contexts, it can also be utilized by institutions as a smokescreen for more cosmetic approaches to Interculturality.

In the following sections I will examine how traditional medical practitioners, especially the members of AMUPAKIN, negotiate these multiple roles and attempt to challenge and influence the affirmative biopolitics of the state. In the first section, I examine how traditional practitioners' discourses of *Buen Vivir* and Interculturality contest state notions of the Good Life and how it should be achieved. In the second section, I analyze how they navigate multiple roles amidst the implementation of Intercultural Health policies and the changing conditions of Napo Runa life. Finally, I address the personal experiences of traditional practitioners as they negotiate their value in Runa and Ecuadorian society despite significant personal hardships. Throughout these sections, the views and experiences of traditional practitioners provide stark contrast to the ways in which biopolitics shape the work of policy makers and biomedical professionals in the previous chapters. On one hand, the strategies employed by the MSP are seen to conflict with the ways Runa community members engage with both traditional and bio-medicines. On the other, the overemphasis on biopolitical measures is seen to conflict with achieving more radical forms of Interculturality.

5.2.1 Discourses of Traditional Medical Practitioners

For Napo Runa community members and traditional practitioners alike, the reforms brought on by the politics of *Buen Vivir* had made noticeable and much needed improvements in many aspects of everyday life. Communities that were only accessible by foot were now connected to the highway system. Clinics that were irregularly staffed or frequently lacked medications were now offering quality care. They also felt like previously common experiences of discrimination against indigenous peoples in healthcare services had all but vanished. Traditional practitioners and community members alike felt this was due, in part, to the new structures of quality improvement and accountability. As one community member commented:

> “litlle by little they’re eliminating that. but yeah it still happens in some places, but its very little now, because now you can file a complaint, you can complain about a bad employee. maybe because of that they’re more flexible more careful with that.” - Carlos, Runa community member

In another example, a community midwife and local health committee member commented on how she was able to demand care for a patient who was severely ill, despite not having an appointment. Although they recognized continued limitations of the public healthcare system, they noted that the interpersonal relationship with patients was much more caring and supportive than in the recent past.

Traditional practitioners and indigenous community members also approved of the government's adoption of Interculturality as a normative and political principal. They noted it was an important shift in policy towards reversing the assimilationist approaches of the past:

> "The government recognizes us [indigenous nationalities], not just through institutions or delegations, but in the laws. We're not afraid to speak Kichwa in the big cities anymore. Why? Because our constitution supports it and that's really good." - Pancho, Herbalist and husband of community midwife.
>
> "I think intercultural health is important. I don't know our culture, and I'm indigenous from right here. I want to know how our culture is. Both my parents were raised by the nuns and monks. So they don't know our culture, they can't explain those things like how we used to give birth at home." – Gisela, Runa community member

As both Pancho's and Gisela's quotes indicate, the new laws supporting Interculturality and plurinationality created opportunities for welcoming and promoting indigenous lifeways in public institutions and Ecuadorian society writ large. Gisela's experience also highlights the importance of such policies within indigenous communities as well. Like many of the Napo Runa families I met, hers had been significantly impacted by the mission schools that attempted to replace ontologies of forest spirits with saints, and punished children for speaking Kichwa. For many Runa from peri-urban communities around Tena and Napo, these schools had significantly limited their access to knowledge of *ruku kawsay* and *sacha ambi*. Such was the case with two of the members of AMUPAKIN, who learned midwifery only after marrying into families with more traditional lifestyles. Thus, many Runa felt these policies were important steps in potentially reversing the historic (and recent) processes of assimilation that had threatened Runa culture.

However, many Runa community members and traditional practitioners often critiqued state discourses of *Buen Vivir*/*Sumak Kawsay* and Interculturality as empty political rhetoric. In many of my interviews I heard variations of, “it’s a beautiful thought, but they’re not doing it”. Despite significant government investment in social support programs and initiatives such as the PLLPI birth rooms, Runa community members felt that the affirmative biopolitics of the state did little to promote the type of Good Life and intercultural reality they sought. Furthermore, several highlighted how the policies increased precarity in Runa communities. In contrast to the mixed (but generally supportive) discourses of policy makers and biomedical professionals, Napo Runa discourses of Interculturality and *Buen Vivir* questioned the intent and impact of government policy. Ultimately, these distinctions were based on different definitions of what *Buen Vivir* and Interculturality mean. I argue these distinctions are based on Runa preference for relational politics over the biopolitics they feel are prioritized by the state.

5.2.1.1 Sumak Kawsay versus Alli Kawsana

As discussed in Chapter 1, state discourses of *Buen Vivir* and *Sumak Kawsay* are radically different from indigenous perspectives of well-being, despite being presented as the same. This difference is clear in conversations with Napo Runa, where many of my interlocuters were quick to distinguish between *Sumak Kawsay* and *Alli Kawsana*. Like many other researchers in the region have noted, *Buen Vivir* and *Sumak Kawsay* are seen as two names for the same government policies that promote social welfare and environmental protection through extractive industries. In contrast, *Alli Kawsana* is driven by reciprocal relations between humans and non-humans that promotes mutual care and health (Whitten and Whitten 2015, Bridges 2017, Uzendoski 2018, Jarrett 2019).

As many Runa community members noted, the government policies of *Buen Vivir* had significant impacts on the ways they and their families were able to live their lives. For them, a good life comes from living comfortably, with the healthy food and relationships epitomized by

Ruku Kawsay. This point in particular was highlighted in a conversation between AMUPAKIN midwives[61]:

> "Hortencia: everything the government says about *Sumak Kawsay* is worthless [mana valin]. **How we lived before, in the beginning times, that was Sumak Kawsay** [ñukanchi kallari timpu kawsanun *Sumak Kawsay* aka]. Catching fish, hunting and eating meat. That was good. That's what we want from *Sumak Kawsay*. That's what makes us happy. **But now, to have Sumak Kawsay you need money for <u>everything</u>** [emphasis original]. To pay for electricity, for water, for taxes. And now things are more expensive too. You used to be able to buy a quintile of rice for maybe 50 cents. Our food from before was good food, but now, we don't have it. **Where are they finding this Sumak Kawsay? It's all run out while they go around talking about some supposed Sumak Kawsay**.
>
> Cora: and our water is contaminated
>
> Hortencia: and we have to buy toilet paper, and get disposable diapers. And the big game has left the forest.
>
> Gladys: and we have to buy phone minutes, and clothes for school."
>
> – Hortencia, Cora, and Gladys, AMUPAKIN midwives

On one hand, these women are questioning the state's definition of a "good life". For them it is a construction inherently based on mestizo, urban, and market oriented lifestyles that they contrast sharply with nostalgic and romanticized references to the old ways of life in Runa communities.[62] While this critique applies generally to the impacts of market integration that has been taking place since the 1960s, many Napo Runa I talked with reflected on how the obligations and co-responsibilities of *Buen Vivir* reforms have accelerated the pace of cultural and economic change expected of indigenous communities. In this way, *Sumak Kawsay* was seen as a smokescreen for a new form of cultural assimilation and erasure. To this effect, another member of AMUPAKIN

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[61] Ironically, both this quote and the one below from Pablo were prompted by the President of AMUPAKIN as an assignment for her course through the CPCCS on Citizens' rights. It required collecting several people's perspectives about what Sumak Kawsay means to them.

[62] This type of nostalgic and romanticized discourse of *Ruku Kawsay* is increasingly common in indigenous politics and revitalization efforts. For a fascinating and in depth analysis of its forms and functions in Napo see Ennis (2019).

once declared that "*Sumak Kawsay* kills [*Sumak Kawsay* wañuchin]". For them, the affirmative biopolitics of the state espouse the acceptance of a plurality of lifeways, but the actual biopolitical targets it sets out to achieve ultimately undermine the biolegitimacy of indigenous values and ways of life.

On the other hand, the midwives above are also critiquing how policies that reinforce state standards of a Good Life negatively impact their lives in practical ways. As many Runa community members told me, those new expectations carry with them significant social and economic costs that make *alli kawsana* harder to achieve, even when they agree with changes such as universal education and biomedical care. In group interviews with community members, these changes were often expressed in discussions of sending children to school. The costs and time commitment of school were seen to contribute to increased tensions in spousal relationships (around family planning and gendered labor roles), increased reliance on purchased low-nutrient food, and inability to pass on traditional knowledge through experiential learning. Although they recognized increased social support programs such as the *bono*, they felt it did little to meet the rapidly increasing economic needs of Runa families, especially given the lack of long term job opportunities in the region. As Pablo describes below, the rhetoric of *Sumak Kawsay* merely obfuscates the ways the state intervenes in and conflicts with Runa lives:

> "For me *Sumak Kawsay* means nothing. Because in Ecuador, **through the government's policies they manage a person's life.** But in the government it's all about business or promoting yourself to look good. The essence of *Sumak Kawsay* itself doesn't, and will never, arrive from political power. Personally, I'm just as poor now and have even more needs. **For me, the real Sumak Kawsay is that they leave us alone and let us enjoy our nature** [disfrutar de nuestra naturaleza]."- Pablo, socio of AMUPAKIN

As Pablo argues, the rhetoric and metrics of *Buen Vivir* serve to create a better image for the state, but have done little to change his own life or those of the people around him.

In these ways, Pablo and other Runa I interviewed challenged the notion that *Sumak Kawsay*/*Buen Vivir* truly reflects the ways they perceive well-being in their own lives. This distinction was astutely encapsulated in Bridge's study of the production of well-being in a Runa community near Tena:

> *Sumak Kawsay* is a state-sponsored invention that both co-opts and homogenizes indigenous cosmologies. *Alli Kawsana*, on the other hand, reflects the experience-near goals of Napo Runa themselves. Whereas the policy of *Sumak Kawsay* proposes a watered-down and reductive notion of wellbeing, Napo Runa enact *Alli Kawsana* through vivid interactions with family members and an assortment of cultural outsiders, while engaging with surrounding ecologies (2017, p. 278).

Adding to Bridge's analysis, I argue that at the heart of this distinction between *Sumak Kawsay*/*Buen Vivir* and *Alli Kawsana* is a preference for **relational politics** in Runa communities over the **biopolitical agendas** emphasized by the state. *Alli Kawsana* is an inherently relational proposition, where obligations and benefits are circulated in an economy of care. In contrast, *Buen Vivir* is not only based on mestizo values of the market economy and institutional education/ health, but it also reduces those values to measurable statistical goals. In doing so, it is seen to ignore the secondary impacts of those goals and policies on people's lives and social networks. Thus, *Buen Vivir* and *Sumak Kawsay* are inevitably viewed as an imposition from an outsider rather than a shared goal. In this way, Runa discourses on *Buen Vivir* align with those of indigenous activists who argue it is merely cosmetic rhetoric covering continued (and possibly strengthened) systems of control.

5.2.1.2 Interculturality and the Problems of "Mutual" and "Exchange"

In the context of Interculturality, everyone I interviewed employed a discourse of the general principle that was very similar to those of state policies and biomedical practitioners. As the quotes below highlight, traditional practitioners and indigenous community members also defined Interculturality as a mutual dialogue with shared benefit for all:

> "I like that, Interculturality. It's beautiful to share with everyone, to demonstrate our knowledge and our culture that our parents have left us, and likewise to learn from the other side, to learn yourself. Doing an exchange." - Oswaldo, Community Yachak

> "For me, it's getting to know many cultures, getting to know each other between cultures. In health, it would be that they would also teach the traditional stuff with the modern stuff, to take both medicines by the hand so you can have more alternatives and variety." – Carlos, Runa Community Member

Like the policy makers and biomedical professionals in the previous chapters, traditional practitioners and Runa community members alike felt that Interculturality in health was fundamentally about respect and exchange between biomedicine and traditional indigenous medicines. In contrast to some policy makers and biomedical professionals, however, they felt this approach benefited all providers and patients alike.

In addition, all of the traditional practitioners and Runa community members felt that Interculturality in health was not being achieved. Their perspectives about Interculturality were immediately followed by statements that challenged the perceptions of many physicians and policy makers that Interculturality was taking place in the public healthcare system:

> "If we think about Interculturality in the health field, they're not applying it. They should but they aren't. The state isn't guaranteeing the right to ancestral medicine. For me there's a lot left to do on the part of the authorities. It's important so we don't lose our ancestral customs, and because natural medicine is getting more important, even here in the city." – Carlos, Runa Community Member

> "Since the government is always saying Interculturality and pluriculturality, they should equally strengthen natural medicine just like medicine from the clinic, respect the midwives and yachaks so they can give their knowledge, their customs, their traditions to everyone."- Wanda, Runa community member

Both quotes demonstrate a significant division between the expectations of Interculturality in Runa communities with those of some biomedical professionals and policy makers. They underscore that the purpose of Interculturality is to guarantee the right for all Ecuadorians to access ancestral medicines as well as biomedicine. This perspective aligns with views of more “radical” policy makers and biomedical professionals, who also tended to be indigenous themselves or had significant personal experiences with traditional or natural medicines. However, it conflicts sharply with Reductionist policy makers who view Interculturality as only for indigenous populations, and with biomedical professionals who defined it as merely non-judgemental relationships between patients and providers.

I argue, this difference of expectation likewise stems from a preference for relational politics over the biopolitics of the state. This perspective was perhaps best epitomized by following quote from Oswaldo:

> “If we do it like in the constitution, it would be really good, really practical. But we don’t do it. Like up to now I see we’re still separated, we don’t have that sociability or that full relationship.” – Oswaldo, Community Yachak

At the heart of this critique of state approaches to Interculturality is nature of the relationship between traditional medical practitioners and the public healthcare system. As Oswaldo notes, there remains a noticeable separation between medical practitioners. He contrasted this with a story of his friendship with a local physician. They would have long conversations about how each would diagnose and treat certain illnesses, and report back to each other about any of those practices they attempted with their own patients. Likewise, they would refer patients to each other when they felt their approach would not work. Through this story, he underscored that the primary basis of Interculturality is the mutuality and shared benefit of the relationship between the two parties.

Runa community members and traditional practitioners felt Interculturality only existed as rhetoric precisely because of the inherently unequal relationship between public health services and traditional practitioners:

> "If the people from the city want to come and support our association, great. Come and support us. Don't tell us what to do. Help us reinforce what we already have." - Pablo, socio of AMUPAKIN

As Pablo described, the relationship experienced by many traditional practitioners was neither mutual nor equal. As such, the notion of knowledge exchange between the two parties is inherently problematic. In this view, if the relationship is unequal then any exchange of knowledge is either one-sided or reifies the already existing power imbalance. If the relationship was equal, as in the case of Oswaldo, then exchange of knowledge is less problematic. Because the biopolitical agendas and policies of *Buen Vivir* are seen to primarily promote biomedicine, they ultimately reinforce these unequal relationships. In this way, these discourses of Interculturality much more closely aligned with the radical visons of the indigenous right's movement that sought to reverse biomedical hegemony through self-determination over healthcare services.

For traditional practitioners and Runa community members, this preference for relational politics over biopolitics represents a fundamental divide between themselves and the state. However, these perspectives should not be mistaken as incompatible ontological positions, but rather preferences for one type of political framework over another. While it is likely these arguments for a relational politics are influenced by values of *alli kawsana*, it does not mean that indigenous people inherently reject the function and purpose of biopower altogether. As I will show in the following section, traditional medical practitioners often engage with and negotiate biopolitical controls in complex ways. In doing so, I will show how Runa community members and traditional medical practitioners feel that an overemphasis on state-determined biopolitics rather than relational politics has important consequences for community well-being and attempts at implementing Interculturality in health. In many ways, these perspectives highlight the impacts of and reactions to the choices made by policy makers (Chapter 3) and MSP providers (Chapter 4) as they designed and implemented the affirmative biopolitics of the state.

5.2.2 Traditional Practitioners and Implementation of IH

In Chapters 3 and 4, I examined how policy makers and biomedical professionals negotiate conflicting discourses of Interculturality as they attempt to operationalize it in both the national healthcare system and the local context of Napo Province. In both of these groups, perspectives of what Intercultural Health should achieve and how varied widely, but pre-existing hierarchies and political structures ultimately limited attempts at more radical forms of integrating traditional medicines within the MSP. In contrast, traditional medical practitioners are largely external to those processes of design, implementation, and evaluation. As the primary agents of traditional medicines within indigenous communities, their perspectives of and relationship with the policies of the MSP are markedly different. In this section, I examine how the implementation of IH policies is understood by traditional medical practitioners, and the various strategies they use to negotiate their roles within it. In the first subsection, I discuss how traditional practitioners feel the current policies towards birth and Interculturality misrepresent perspectives of choice and risk in Runa communities. In the second, I examine how traditional practitioners challenge the biopolitical mechanisms enacted by the MSP and attempt to negotiate their role within them through relational politics.

5.2.2.1 Conflicting Perspectives of Choice and Risk

As discussed in the previous chapters, Intercultural Health services in Ecuador are presented as a strategy to both respect patients' choice of using ancestral medicines, and improve health outcomes for priority populations. With the emphasis on PLPPI rooms and reduction of maternal mortality rates, these policies are based on specific assumptions of how women choose to access different kinds of medical care. In Chapter 3, I explained how those assumptions were based on statistical "gaps" in maternal mortality and institutional births among indigenous women in the 2004 ENDEMAIN survey. Through the survey results, these differences were explained (in part) by preferences for local customs and experiences of mistreatment in biomedical establishments. In Chapter 4, I addressed how the implementation of healthcare reforms was meant to address the primary barriers to accessing biomedical services, including universal coverage, expanding services, community-based care, ensuring *calidad y calidez* [quality and warmth] ,and adapting services to local practices. Despite attempts to incorporate traditional practitioners in formal and informal ways, the policies ultimately channeled care to the public healthcare system.

For Napo Runa community members and traditional practitioners, these policies are based upon two erroneous assumptions of choice and risk. First, is that biomedicine is the only system that effectively reduces/eliminates risk. In this way, policies are seen to reinforce a hierarchy of resort that does not accurately represent or respect the ways people seek care. Second, is that the policies are expanding patient choice in healthcare. As my interlocuters described, their options for care (especially for birth) are actually decreasing, which limits their ability to give birth in a manner they feel is both safe and comfortable.

In Chapter 4, I discussed the frictions between local biomedical professionals who felt traditional medicines are as effective as biomedicine and those who felt patients utilized biomedicine when "less effective" traditional practices were no longer working. This latter model of care seeking was once a prominent theory of patient choice in situations of medical pluralism, often referred to as the "hierarchy of resort" (Romanucci-Ross 1969). However, it has been widely challenged since the 1970s for the ethnocentric assumption that biomedical care is always better than non-biomedicine at managing illness, and for ignoring the complex socio-structural limitations that can prevent people from accessing their ideal form of care (Lane and Millar 1987, Crandon-Malamud 1991). Furthermore, patients and practitioners often combine medical approaches and switch between them throughout the course of their therapeutic itinerary (Broom, Doron et al. 2009, Mukharji 2016), as is the case in Napo.

While IH policies attempt to respect patients' choices to use traditional and other alternative medicines, the emphasis on priority populations ultimately reifies biomedicine as the only system capable of diagnosing and mitigating risk. This is most clearly seen in the maternal mortality and birth policies discussed in Chapter 4, where midwife trainings and outreach campaigns urge patients to be seen at the closest clinic as soon as possible given any sign of risk. Unlike policies in other countries that penalize women for birthing at home or with traditional birth attendants (Guerra-Reyes 2019), the hierarchy of care in Ecuador is largely enforced through fear of complications/death and mechanisms of biopolitical coercion. The *Bono de Desarrollo Humano,* for example, only counts checkups at biomedical institutions as meeting conditions for cash transfers.

Interestingly, none of the women I encountered mentioned the Bono as a factor in deciding where to receive prenatal or birth care. Instead, they cited public discourses of risk that equated home birth with death, and to a lesser degree a lack of knowledge/availability of traditional midwifery. Although they generally agreed that hospitals are better equipped to manage any potential complication, they questioned the implication that traditional midwifery was incapable of preventing or treating obstetric risk.

For nearly all of the women I encountered, a primary concern was whether or not they would need a c-section. The women, midwives, and doctors I met described c-section as a necessary procedure in case of obstetric and neonatal complications. For biomedical providers, the need for non-emergent c-section was most commonly attributed to a baby's position in utero, wrapped umbilical cord, and cephalo-pelvic disproportion[63]. In contrast, Runa women generally attributed the need for c-section to the baby's position and a woman's strength and ability to give birth. As several midwives stated, "if they can do it they give birth at home, if they can't we send them to the hospital". While providers felt c-section was the primary method of mitigating risk from those complications, the Napo Runa women I interviewed emphasized the ways Runa practices provided important sources of risk prevention and mitigation.

Within traditional midwifery, there were several methods of giving women the strength needed for birth. This included herbal teas many women would drink (including before a planned hospital birth) that gave them energy and encouraged fast labor. Napo Runa birth practices also gave women physical strength for pushing. This included having a family member physically support the mother during the expulsion period (see Figure 2), and using the suspended rope to help bear down while pushing. This was frequently contrasted with lithotic births in the hospital, where women were "left to give birth on their own" with the doctors only present to catch the baby. As one woman who had just delivered at the hospital described, "there's nowhere for you to

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[63] When a baby is too large or a birth canal is too small for vaginal birth. Many recent studies have questioned the formulas used to determine cephalon-pelvic disproportion, which are based on European populations despite a wide variety in shape and size of birth canals around the world Betti, L. and A. Manica (2018). "Human variation in the shape of the birth canal is significant and geographically structured." Proceedings of the Royal Society B: Biological Sciences **285**(1889): 20181807..

get strength from”. Likewise, traditional diets and lifestyles were seen to make women stronger and better able to endure the pains of childbirth. Although only the elderly I interviewed had practiced *sasinas* associated with pregnancy and birth, all of the Napo Runa women I interviewed commented on how shifts away from *Ruku Kawsay* made women weaker. No longer practicing *uchu churana* [placing hot peppers in eyes], eating more “contaminated” city food, and having more sedentary forms of work made women less capable of bearing the pain of childbirth and of having enough strength to birth the baby naturally. As one group interview participant stated, “before they were really strong, now we’re weak. That’s why we go to the hospital.” This weakness, in turn, was seen to prolong labor and increase the need for c-section.

This perception of increased weakness, as well as state campaigns against maternal mortality, were primary drivers for women’s overall preference to give birth at the hospital. Even so, all of the Napo Runa women I interviewed (and even several mestizas) who had given birth in the last 5 years had seen a midwife for a prenatal visit to ensure the proper position of the fetus. This practice was a widespread method of preventing birth complications and the need for c-sections. As several midwives and community members noted, the hospital in Tena had a reputation of “cutting women open” when it was not necessary (*yanga partichinun*). During preliminary research in 2013 the C-section rate at the hospital was approximately 40%, but after implementing strict case revision standards it had been reduced to 20% by 2016 (Interviews with Hospital Directors, 2013 and 2016). Even as midwives and community members recognized that change, they knew it was important motivation for the continued widespread practice of seeking out midwives to reposition babies in utero.

As noted in previous chapters, biomedical providers and policy makers generally accepted this practice, and recognized it’s likely contribution to lowering C-section rates. This acceptance is understandable, as manual repositioning (external cephalic version) is also practiced in biomedicine, although much less widely and with fewer techniques than those used by traditional midwives[64]. For the patients, traditional practitioners, and biomedical providers who supported this practice, the skills of traditional midwives were seen as important contributions to patient care:

> "The ultrasound only sees how the baby is. But a midwife knows how its going to be born. If its in a bad position the doctors just do a C-section. I think it'd be better to have an ultrasound and a midwife, so you could see how the baby is and she can position it." – Raúl, Runa community member

For them, this mostly uncontroversial practice of midwives was further evidence of the continued importance of traditional medicines within the public healthcare system. In this way, midwives' experience and skill was seen as both complimentary to biomedical care and an additional method of mitigating risk.

But, traditional medical practitioners were also seen to effectively treat patients in situations where state policies would have clearly mandated referral to biomedical care. In one scenario I witnessed, a pregnant Runa woman associated with both AMUPAKIN and the MSP clinic had classic signs of pre-eclampsia: headache, swollen feet, and high blood pressure. She wanted to give birth with the midwives, but her doctors and physician colleagues urged her to deliver via c-section at the hospital given her high risk for complications. She decided to consult a *yachak*, who swept her for *mal aire*, gave her samai, and foretold that if she went to the hospital she would have an uncomplicated c-section. But, if she went to the midwives she would have an uncomplicated vaginal birth. As she described, immediately after that experience her headache

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[64] External cephalic version in biomedicine is generally done around 37 weeks where the provider uses their hands to push/pull on the mother's belly to manually re-position the baby. In contrast, Napo Runa midwives reposition the baby from 35-40 weeks (ideally 35 weeks) using several techniques depending on gestational age. These include hands on belly, rocking in bed sheets, and bathing in rivers, with the latter two preferred as they are more gentle.

disappeared and her physical symptoms improved significantly. With those changes in symptoms, she decided to deliver with the midwives when she went into labor 3 days later. For her birth, the midwives specially prepared an infusion for high blood pressure. I was present when her daughter was born without complications for the mother or the baby. Despite the doctors' concerns, none of them were present at the birth. As the woman explained to me, "I have a lot of confidence in the midwives and what they can do."

Likewise, an obstetrician told me of one of her patients, who had post-partum bleeding and pain. She was concerned it was retained placenta, but with no signs of infection she sent the patient home. She checked on the patient two days later, and found her completely recovered. After being sent away from the clinic, the patient had consulted the community midwife who treated her with massage and a hot poultice, during which she delivered remnants of the amniotic sac. As the obstetrician commented,

> "If she would have gone to the hospital they would have 100% done a manual revision[65]. But I was like, 'WOW' the plants got all of it out, and it's like nothing happened to her. Because when they do the manual revisions its absolutely horrible. Cases like that leave me surprised about all the things natural medicine and midwives can do." – Dr. Yolanda, MSP Obstetrician

In both the case of midwife with preeclampsia and the obstetrician's patient, the intervention of traditional practitioners was understood to be against the biomedical norms for mitigating risk of maternal mortality. However, in both cases traditional practitioners were seen to effectively mitigate that risk and provide both appropriate and less invasive care.

These stories also highlight concerns I heard from the biomedical professionals in Chapter 4 regarding the potential risks created **by** traditional practitioners. While the woman with pre-

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[65] Mostly likely referring ro Dilation and Curettage, where the cervix is opened manually with a long speculum and a suction tube or curette (scraping instrument) is used to remove tissue.

eclampsia did have an uneventful birth, her biomedical colleagues were appalled by her hesitance to go to the hospital for the birth. As several told me in private, they felt some *yachaks* (and especially *sobadores)* jeopardized patient's health by telling them not to see doctors or take medications as prescribed. For them, part of this increased risk was the lack of oversight to prevent charlatanism and malpractice within traditional medicines. Napo Runa community members shared some of these concerns as well, particularly in the case of *yachaks* that had the power to cause illness and death. Likewise, community members were increasingly concerned about *yachaks* who catered to *ayahuasca* tourism but had minimal *paju* or knowledge of *sacha ambi* (see also Tupper 2009, Davidov 2010, Erazo and Jarrett 2018).

There were several ways in which authentic and ethical practice was reinforced amongst traditional practitioners. In my own observations and through casual conversations with my interlocutors, gossip amongst Napo Runa community members formed an important system of social control. This included warning others about the poor outcomes and exhortative prices of certain practitioners, but also more visible measures such as blocking the path to a practitioner's home if they were seen to cause a death. In addition, associations of traditional practitioners, including AMUPAKIN and CYRAE, developed their own codes of ethics to guarantee the care provided by their members (Garcia 2005, Erazo and Jarrett 2018). Upon the founding of CYRAE, for example, the association tracked down and "sanitized" rare stones generally used in harmful witchcraft. While these stones could be used for good, they were seen as too powerful to remain in circulation (even amongst shamans) (Erazo and Jarrett 2018)[66].

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[66] As Erazo and Jarrett note, the seizure and destruction of these stones was controversial amongst shamans, but generally accepted by Napo Runa community members (2018).

Despite these conflicts over potential risk, many of the midwives I interviewed felt the contributions of traditional midwifery are neither counted nor valued by the MSP. This point was most succinctly put by the President of the Cotacachi Midwive's association during a public forum on IH policies. In response to the previous talk given by national IH Director, Paulina Jimenez, she stated:

> "Unfortunately a lot of us midwives don't know how to read or write, and that is a weakness. And that has meant we don't have a registry of all the support we've given society as midwives in terms of the reduction of neonatal and maternal mortality. In all the figures they've shown there, they've made invisible the midwife who many times has made it so they don't do c-sections, or so there aren't maternal or neonatal deaths, or that after birth there aren't complications." – Martha Arotingo, Cotacachi Association Midwife

As Martha comments, the biopolitical targets emphasized through state policies, particularly maternal mortality and c-section rates, only track the efforts of doctors- a direct result of the decisions made by policy makers. In the previous chapter, I discussed how midwives' roles in birth were made invisible through reported data, but this erasure also occurs during the prenatal and post-partum periods. The primary surveillance mechanism for prenatal care is the *carné perinatal*, a folding booklet that a pregnant woman takes to all prenatal appointments. The booklet is designed to provide a universal registry of a woman's pregnancy as it is common for women to be seen at several different clinics, including between private and public services. In the booklet, doctors track prenatal checkups, maternal weight, fundal height, and any complications. Despite being a "universal" document, it only has space to register the "treating doctor". Even in care encounters where doctors and their patients discuss visits to the midwife, there is no form where that information is logged, and no procedure where it is tabulated for population-level calculations that could provide the kind of data Martha proposes. As she describes, the role of traditional midwifery in preventing adverse outcomes is invisible in the evaluative measures of the state healthcare system.

At first glance, the data gathered in pilot projects such as AMUPAKIN or the MSP clinic in Loreto could provide important alternatives of evaluative measures, as both programs maintain their own registries for patients seen by traditional midwives. At AMUPAKIN, one of the obstetricians created a patient intake form for the midwives which included the attending midwife, demographic/contact information, questions about diagnoses before and during pregnancy, status of biomedical prenatal checkups and exams, and new findings from the visit. As Martha comments, these forms were often difficult for the older midwives to complete, given their illiteracy and low fluency in Spanish. Some ignored the forms for these reasons (3 of the 13 midwives I observed), but most of the midwives were diligent about completing them, even if they had to ask younger *socios* or the patients themselves to assist them. For this reason, several of the entries in the registry are incomplete or incorrectly filled out. Another limitation was that the registry only included patients seen at the AMUPAKIN center. Nearly all of the midwives also saw patients in their own communities. While those appointments were sometimes reported at the monthly meeting[67], they were not logged in the registry. Thus, any tabulation of the care provided by the midwives through the registry is likely a gross underestimate.

Despite the existence of these data systems, they remained entirely separate from the clinical records maintained by the MSP clinics at the same locations. The registry was under the sole management of the midwives, and was stored in a separate location from MSP patient records. When patients sought the midwives, they were not checked in by the receptionist, but were simply

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[67] Some midwives reported community care to the association and others did not. For any reported care the midwife was expected to share a small portion of her earnings with the association. While official policy was that all care should be reported, the members left it to each midwife to decide.

told where they would likely find the midwife on shift for that day. Even the registry was not designed to coordinate with MSP clinical histories, as it did not contain a field where the patient's clinical number could be recorded. Even if it did, the midwive's patients often came from communities outside of the clinic's service area and did not have a paper file available at the clinic. According to the obstetrician, the primary reason for creating the forms was not continuity of care, but to ensure the midwives were screening patients for potential risk factors before performing prenatal checkups or births, and to have information available if complications or disputes arose (Interview, 2016). In the case of Loreto, the patient registry was tabulated apart from MSP records, and shared with the County Health Committee[68] who published the total number of patients seen by member midwives in their annual report. Therefore, in the case of both AMUPAKIN and the clinic in Loreto, the existence of data collection procedures did little to shape the surveillance strategies of the MSP. Rather than expand state biopolitical measures to include the work of traditional practitioners, the lack of review/uptake by the MSP left them as merely internal systems of measurement.

In addition to their role in mitigating obstetrical complications, both traditional practitioners and Runa community members felt that midwives presented an important alternative to biomedical care that was often viewed as negligent and even abusive. Throughout my discussions with women in Napo, whether indigenous or mestiza, descriptions of obstetric violence and medical negligence were common. The most frequent complaints were of non-dignified care and abandonment of care[69] at local hospitals. Many women described situations of non-dignified

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[68] An unique interdisciplinary council of NGOs and indigenous organizations that coordinates health activities with the MSP, indigenous communities, Social Security, and local governments.

[69] Following other studies on obstetric violence, I employ the 7 categories of disrespect and abuse in childbirth defined by Bowser and Hill. These include physical abuse, non-consented care, non-confidential care, non-dignified care, discrimination, abandonment of care, and detention in facilities Bowser, D. and K. Hill (2010). "Exploring evidence

care where they were verbally abused while in labor by doctors and nurses. As one woman told me (ironically a married ex-nun), she was actively birthing her first child when the nurse scolded her, saying “see, this is what you get for sleeping around.”

Likewise, women described how doctors at the hospital would only participate in the birth during the expulsive phase:

> “In the hospital they leave you alone laying there in pain, they don’t “watch you” [mana rikunanun]. They’re only there when its time to get the baby.”- Dorotea, AMUPAKIN Midwife
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> “The nurses go off to attend to another patient and you’re there dying alone and it’s like how are you going to go run to get a doctor when the pain is so bad you almost faint? How are they going to know the baby is coming?” – Karen, Runa community member.

Since women weren’t allowed to have companions, this meant they were often alone during the painful contractions of labor. As several commented, they were told to walk the halls (to hasten dilation), go to the bathroom, and even bathe themselves during labor without assistance. Understandably, these situations were not only considered isolating, but also inherently dangerous. In a few cases, they described how doctors and nurses did not arrive on time, and women gave birth in the hallway yelling for assistance. One community member I interviewed (mestiza), had gone to the MSP/Midwife clinic in Loreto to give birth. Although she wanted the birth managed by the doctor, he had fallen asleep and neither she nor the traditional midwife on shift were able to wake him. The baby was delivered without complication by the midwife.

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for disrespect and abuse in facility-based childbirth." Boston: USAID-TRAction Project, Harvard School of Public Health: 3..

For Napo Runa women these experiences contrasted sharply with the characteristics of a home birth managed by a midwife. At home, the midwife and family members provide physical and emotional support, and are ultimately concerned with the mother's comfort:

> "In the hospital it was a different kind of birth, I didn't like it. It was scary, so scary my vagina wouldn't open. In the house, its not like that. With the vine, and your clothes on, you're not afraid. You have somebody there watching [rikuna], you have a helper."- Asunción, AMUPAKIN Midwife

In contrast, the neglect and verbal abuse often experienced at the hospital were seen not only as cold, but at times inhumane. This critique was particularly strong amongst older Napo Runa women, who often equated the unassisted litotical births with the way you would leave a cow to birth alone (*wagrashina).* Likewise, Napo Runa women were critical of c-sections that "cut women open" precisely because of birth settings that were neither supportive, nor gave them strength for vaginal births. It is telling that Napo Runa folklore includes the tale of the Mouse Mother (*ukucha mama).* In the "beginning times" Runa did not know how to give birth, and so they would cut open the mother's belly, needlessly killing her. The mouse mother took pity on them, and showed them how to birth with a suspended vine[70]. In these ways, Napo Runa women highlighted how the methods of biomedical birth ultimately failed to respect the interpersonal and physical needs of the mother, creating new forms of risk despite being effective at reducing mortality rates.

Although not as common, many women also told me of more severe forms of obstetric violence including physical abuse. This was more common amongst the older generation (50 years an older), who reported being berated with racial slurs as they delivered, or even of having their arms and legs restrained during labor. Midwives and community members alike recognized that

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[70] This tale was first related to me by Elodia Dawa, a renowned Pastaza Kichwa potter, but was later reiterated by several of the older midwives of AMUPAKIN. A similar legend has also been recorded in Zápara communities (Pallares 2001).

these practices where now exceedingly rare given recent reforms in the healthcare system towards patient's rights and complaint investigations. However, two of the women I interviewed who had given birth in the last 4 years reported serious allegations of physical abuse and non-consented care related to the controversial Kristellar Maneuver[71] where significant pressure is applied to the top of the uterus during the expulsive phase to help manually push the baby out of the birth canal. In one case, the mother was left badly bruised after three medical residents pushed on her at the same time, despite her pleas for them to stop. As she reported, they pushed so hard blood came out of her eyes and she nearly lost her vision. For midwives and community members, these experiences of obstetric violence once again highlighted the potential risk of biomedical birth, but also the injustice of biopolitical systems that question the work of midwives while letting such cases of biomedical mistreatment go unrecorded and unpunished.

This dynamic is perhaps best represented in the birth story of María, a white Argentinian immigrant who sought a home birth with the midwives of AMUPAKIN. As a first-time mother and proponent of humanized birth, María completed regular prenatal checkups at her local MSP clinic and with the midwives. Once her labor began, I went to her home with the midwives who repositioned the baby (from transverse position) and guided her partner on how to support her during contractions. Her water broke during the beginning of the first stage of labor, and after 13 hours of contractions without fully progressing to the second stage of labor she became worried about the health of the baby. Despite the midwives' reassurances that her labor was progressing

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[71] Also known as Uterine Fundal Pressure During Second Stage of Labor. The procedure is understudied, but recent research has suggested it significantly increases risk of complications for both mother and baby. For these reasons, the procedure is legally banned in the USA and the EU, but is still widely practiced worldwide Malvasi, A., S. Zaami, A. Tinelli, G. Trojano, G. Montanari Vergallo and E. Marinelli (2019). "Kristeller maneuvers or fundal pressure and maternal/neonatal morbidity: obstetric and judicial literature review." The Journal of Maternal-Fetal & Neonatal Medicine **32**(15): 2598-2607..

normally, María requested to be transferred to the hospital. The midwives called an ambulance and she was taken to the Tena hospital. In María's words, her experience at the hospital was "everything I feared would happen and worse." As she later told me, she was immediately separated from her partner and left unattended in a labor ward with several other women. When it was time for her to push, two doctors simultaneously performed the Kristellar Maneuver despite her protests. For her, the experience was severely traumatizing not only from her experience of obstetric violence, but also because the doctors pressured her several times to file a malpractice complaint against the midwives. She refused, citing how the midwives' repositioning of the baby made it possible for her to deliver her daughter vaginally without complications.

In addition, midwives commented that these experiences have made planned home births riskier in recent years. As biomedical obligations have increased and care has improved, the women who decide against institutional births are increasingly doing so as a response to obstetrical violence rather than as a preference for traditional practices:

> "If they can't do it at home we send them to the hospital. More women now say, 'No, don't send me to the hospital'. But with her fear we send her to the hospital." – Asunción, AMUPAKIN midwife

As Asunción notes, in these cases women often refuse to be transferred to the hospital even when complications arise. During one birth at AMUPAKIN, a woman purposefully withheld that she had a hernia because she wanted to avoid c-section at all costs. Her mother who accompanied her had suggested birth with the midwives after her own traumatic birth experience at the Tena hospital several decades before. In my discussions with Runa community members, it became clear that obstetric violence had become a form of intergenerational trauma in many families. While MSP providers and officials recognized womens' fears, they underestimated the continued fear in spite of new (and limited) reforms, and also ignored the impacts such fear had to midwifery practice.

For the women and midwives I interviewed, these experiences of obstetric violence also highlighted important failures of MSP birth and accountability policies. As evidenced in María's story, the emphasis on biomedicine's responsibility for reducing mortality enabled the scapegoating of traditional midwives while obfuscating dangerous practices within biomedical institutions. This complaint was particularly strong amongst traditional midwives:

> "The doctors harm a lot of people but nobody files complaints because they don't have money. They blame the midwives and investigate them. But they harm a lot of women. Now there's a law that sends doctors to jail for malpractice, and they're afraid." – Cora, AMUPAKIN Midwife

> "When we transfer our pregnant compañeras to the hospital, sometimes their mother or the sister catches the baby because the doctors are asleep. How can I guarantee that care again to another woman? Who managed the birth? They're not going to put the mother. They're going to put doctor who was on shift." – Martha Arotingo, Cotacachi Association Midwife

Although the legal persecution of midwives and other traditional practitioners has decreased significantly with the new constitution (per interview anecdotes), other studies in Ecuador have documented continued pressure by biomedical professionals to blame midwives for adverse outcomes even when complications would have happened regardless of where the patient gave birth (González G. Jorge 2010). For this reason, both AMUPAKIN and the midwife association in Cotacachi manage births in pairs, so there is always a witness. As the second quote points out, the process of obfuscation and scapegoating is inherently biopolitical, as doctors' formal accounts of birth are the only ones registered in systems of surveillance and valued by authorities.

Furthermore, midwives and Napo Runa community members also felt MSP policies for more humane care ultimately left biomedicine to police itself. They recognized that recent reforms in the public healthcare system had dramatically improved patient care in the last 5 years. These efforts included accountability measures patient rights' trainings (see Chapter 4), inclusion of humanized practices in standards of birth care (see Chapter 3), and stricter guidelines against medical malpractice in the updated penal code of 2014. However, these changes did not prevent María's experience of obstetric violence, even though the standards of birth care at the time advised against the use of the Kristellar Manuever (MSP 2015). Nor would the reforms prevent the manipulation of patient records as Martha describes above. Through these stories, midwives and community members questioned whether the system that enabled and perpetuated obstetric violence is capable of changing on its own. As one midwife argued,

> "I think a midwife needs to be at the hospital, so we can check to see if they're doing it right or wrong…If a woman dies, there's no witness there to know if the doctors were doing things well or not. No family that sees what happened. We want one of us there to pass their voice and be a witness." – Maruja, community midwife

As several midwives and community members noted, the presence of a midwife within medical institutions could provide a counterpoint of surveillance against harmful biomedical practices. By integrating midwives into the hospital, patients and families would have an advocate for more respectful and supportive care and against unnecessary c-Section. This effect was shown in a 2010 study of the Intercultural Birth program at the Otavalo hospital, where traditional midwives were able complain on behalf of patients and leverage their relationships with management to ensure patient complaints were investigated (Llamas and Mayhew 2018). Thus, some midwives argued for a more relational politics of care where they would ensure a patients' comfort was taken into consideration. Rather than contrast this role with existing structures of surveillance, they argued they could help ensure biopolitical controls accurately reflected patients' experiences.

This critique of self-imposed change was more broadly applied to recent approaches for more humanized and culturally respectful care, particularly the implementation of PLPPI rooms in select hospitals and clinics. For the Napo Runa I interviewed, even when doctors provided respectful care, they did not know how to provide the kind of supportive care PLPPI policies were designed to provide. Although only two of my interlocutors had birthed at a PLPPI location, many used their experiences at the Archidona hospital to voice their concerns. As a private hospital run by the Josephine Archdiocese, the hospital operated under different protocols than the public hospital in Tena. There, family members and even midwives were allowed to accompany the woman during the first stage of labor, and rarely (depending on the preference of the doctor) fathers were allowed to be present for the birth.

> "The midwives treat women better than the doctors. They're women and mothers, so they know what it's like. They know how to help grab you, give massages, have you sit or stand. They take charge of the birth. But the doctors only help you push and push, but they don't even grab your hands or anything." -Gisela, Runa community member
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> "In the Archidona hospital when my son was born it was stressful as a father, because they don't give you that same confidence like a midwife. It was just me helping my wife while she had contractions. But with the midwives they're there helping, guiding, watching, blowing, massaging, giving teas. In the hospital, no, they just give pitocin and wait for the pains to come. Now I value our world, our culture, a lot more after watching my kids be born in both kinds of care." -Pablo, socio of AMUPAKIN
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> "If just doctors do vertical birth, it's not going to be the same as with midwives. They won't give medicinal teas, they don't know all the other positions. They use different positions and still say they're doing it." – Paulina, AMUPAKIN Midwife

As these quotes highlight, Napo Runa community members and midwives challenged assumptions made by MSP policy makers when they claim that PLPPI is meant to be "just like home birth, but at the hospital" (interview with Zone 2 IH Coordinator). In all of my discussions with people about the new policies, they overwhelmingly approved of the changes that allowed a birth companion, non-lithotic birth positions, wearing personal clothing, and food and drink (particularly medicinal teas). However, they underscored that these improvements remained fundamentally different from home births, where midwives actively managed the exchange of care between herself, the family, and the birthing mother. As discussed in Chapter 3, the surveillance of PLPPI care was ultimately designed to measure compliance with material/physical components of care, rather than to support the relational experiences of the women giving birth or their companions.

Finally, Runa community members and traditional midwives challenged the notion that healthcare reforms, including IH policies, expanded patient choice in care. On one hand, this included critiques of the assumptions of choice in "free position birth". As noted previously, the limited application of PLPPI gave women little choice over their birth position. However, as midwives and community members noted, this was choice was a false one from the start:

> "They asked me in what position I wanted to give birth, but since it was my first time I didn't know. So I just said laying down. I didn't remember that the midwives did birth kneeling like that." – Rita, Runa community member
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> "I didn't know what to say. Because in the moment of giving birth, that's when you decide how to situate yourself. Because we don't know how it's going to be. I thought when I was going to give birth that I would do it standing. But with my first birth, I just wanted to lay down, I didn't want anyone to touch me."- Paulina, AMUPAKIN Midwife

As these women describe, any pre-determined choice of birth position is ultimately meaningless. The midwives especially noted that every birth is different, and positions needed to be adjusted according to the mother's needs in the moment. Likewise, as Rita notes, most women are unaware of the myriad positions available and how they are best applied. As I addressed in Chapter 4, even biomedical professionals providing PLPPI care relied heavily on the experience of traditional midwives to manage non-litotical births. This practical experience and managerial role of midwives was the most commonly cited reason for why midwives should be integrated into the public healthcare system. In this way, the presence of midwives would enable better informed and better supported choices during care at the hospital.

Napo Runa community members highlighted, furthermore, that their choices of where to give birth were becoming increasingly limited. Women who feared obstetrical violence at the hospital in Tena used to be able to give birth at home with the community midwife, at AMUPAKIN, or at the private Hospital in Archidona that was commonly regarded as providing more humanized and respectful care (and fewer c-sections). In Chapter 4, I discussed how MSP policies reinforced institutional births as the only legitimate option for care. As many women and midwives described, other pressures were likewise limiting their ability to access alternative care.

> "Now everything has to be done through the state system. You can't go to the private hospital anymore, you have to already be having the baby. If not, they'll send you home or to the hospital in Tena." – Rita, Runa community member

> "Now the young people don't want to learn how to be a midwife. Because they say there's a hospital, we don't have to give birth at home. If a patient is in a grave condition or almost dead they'll report against you." – Maruja, community midwife.

As the quotes above describe, it was becoming more difficult to access both institutional and non-institutional forms of birth care women felt was more humane. The hospital in Archidona, for example, stopped managing births in 2014 and instead transferred patients to the hospital in Tena. As the director stated, this was due in large part to increased investigations and sanctions for cases of maternal and neonatal death (interview, 2016). In this way, state emphasis on biopolitical objectoves significantly limited the ability of other biomedical institutions to provide alternative options for birth. Likewise, the threat of penalization was an important factor in the loss of traditional midwifery within Napo Runa communities. As several women and biomedical professionals commented, when midwives retired or died they were not being replaced, which left many Napo Runa communities without a midwife.

For the community members and midwives who lived outside of urban centers, this rapid loss of experienced midwives and traditional medical knowledge created newfound risk of maternal mortality in communities that still had relatively difficult access to institutional births. Roughly 30% of the women I interviewed under the age of 50 (n=5 of 16) had unplanned home births or delivered en route to a hospital or clinic, either alone or with the assistance of inexperienced family members. In fact, 2 of the 3 maternal deaths in the local health district in

2015 were related to home births attended by family members. Likewise, half of the midwives I interviewed managed at least one birth that was intended for the hospital, including on the footpaths leading out of their community. For Maruja, a community midwife outside of Tena, these scenarios were the primary reason she continued to work as a midwife and urged her middle-aged niece to learn from her:

> "If I get too old or die all of a sudden, Who is going to continue my work in the community? There's nobody following in my footsteps. So if you're taking a woman to the hospital and you have to go by foot, what happens if she gives birth right there in the middle of the path? Who is going to care for her like that, in an emergency?" – Maruja, community midwife

As several women commented, the widespread loss of traditional knowledge in general meant that fewer people (midwives or not) were able to assist in the case of obstetric or other emergencies. This meant Napo Runa communities were increasingly reliant upon biomedical care for health needs (in part out of preference), but there was a rapidly decreasing safety net in cases of emergency or where gaps in access to biomedical care persisted.

I argue these frictions over choice and risk between Napo Runa and MSP policies highlight points of contention between the relational politics preferred by Napo Runa traditional practitioners/community members and the biopolitics emphasized by state health campaigns and the national Plan for *Buen Vivir*. As I argued previously, the state campaigns to achieve improved targeted health indicators were intrinsically based on the assumption that biomedicine is the only system truly capable of mitigating risk, which was generally disputed by traditional practitioners and Napo Runa community members. First, this meant that no systems of biopolitical surveillance were created to measure the contributions of traditional medicines in achieving those goals. Rather than dispute those biopolitical structures entirely, traditional practitioners (especially midwives), argued for structures that would include their work in the systems of surveillance and value of the state. Second, the emphasis on outcomes overshadowed patient experiences, particularly in terms of obstetric violence. The MSP was attempting to address these issues in large part through Intercultural Health initiatives (see Chapter 3). However, Napo Runa felt traditional practitioners were more skilled than biomedical professionals at mitigating those forms of interpersonal risk from biomedical practice. However, as I will detail in the next section, the primary point of friction for traditional practitioners and Napo Runa community members was not how traditional medicines were counted, but what it means for the state to "value" traditional medicines.

5.2.2.2 Negotiating Value of Traditional Medicines

For the traditional practitioners and Napo Runa community members I interviewed, the value given to traditional medicines by the state was fundamentally determined by the relationship between the MSP, biomedical professionals, and traditional practitioners. In Chapters 3 and 4, I examined how the surveillance and implementation of MSP policies prioritized the completion of activities that acknowledged traditional medicines but often alienated traditional practitioners. In this section, I will discuss how traditional practitioners, especially the midwives of AMUPAKIN view their relationships with the MSP. For them, traditional medicine is only truly valued when there is a lasting reciprocal relationship where both parties are equally involved and derive equal benefit. Traditional practitioners attempted to foster those kinds of relationships and access benefits of their knowledge both within and outside of the public healthcare system. Through these activities, they negotiated the value of traditional medicines as both a legitimate medical practice and as a cultural symbol of *Runa Kawsay* [Kichwa way of life].

Regardless of their ties with the MSP (or lack thereof), traditional practitioners emphasized that the foundation of a truly respectful relationship with biomedicine is the recognition of each others' specialized knowledge, epitomized by mutual referrals based on patients' needs. When asked of their relationship with local doctors, all of the traditional practitioners largely defined their response by whether or not the biomedical professionals in their community referred patients to them or sought traditional treatments for themselves:

> "The doctor that is here now, he's recommending the midwives a lot to the patients. With one patient he said, 'I'm going to give you this medicine, but if you like or value natural medicine the midwives are also here and they also cure a lot of illnesses and you can go see them.'" – Paulina, AMUPAKIN midwife and MSP staff

For them, this relational network of care was the purest demonstration of the value of traditional medical practice in the national healthcare system. On one hand, it literally promotes the use of traditional medicines by sending biomedical patients to traditional practitioners. On the other hand, it legitimizes the skill and knowledge of traditional practitioners as healthcare providers in their own right. Through these mechanisms, mutual referrals were seen to reinforce a more equitable relationship that prevented the dominance of one system over another.

However, as the following quote highlights, these relationships were few and far between:

> "The doctors stay amongst themselves. We try to talk with them, be partners with them, the two together. But they value their medicine more. We send patients to them, we tell them to go see the doctors. But there isn't that kind of help from them. They don't want to get to know our medicine well." – Cora, AMUPAKIN Midwife

Most practitioners referenced one or two local doctors who would refer or share knowledge. But, those relationships were uncommon and often short-lived as doctors frequently relocated (see Chapter 4). As several traditional practitioners noted, older and more experienced doctors were more likely to form these mutual relationships than young rural-year doctors who were becoming more common. The forthcoming APKAM Manual for formally articulating traditional midwives in public clinics tried to remedy this by creating reporting requirements on referrals between midwives and MSP providers (see Chapter 3). However, the policy only enforces counter-referrals back to midwives who had originally referred their clients to the MSP clinic. It does not count new referrals of patients from doctors to midwives (or other traditional practitioners). While this measure is perhaps the most significant attempt at an affirmative relational method of survillance, it remains one-sided with the effect of funneling only maternal care to MSP services.

Likewise, traditional practitioners argued their specific practices and knowledge were not valued as legitimate medical practice. As Jordan describes in her foundational work on birth, relationships between traditional birth attendants and doctors are often defined by "authoritative knowledge". This is the knowledge upon which decisions are made, typically at the expense of other forms of knowledge (Jordan 1997). For traditional practitioners, the ideal relationship is defined by shared decision-making and complimentary care:

> "I think one thing, the doctor thinks another thing. So we both have to combine/join together [compaginamos] on the same level and that way we can both share and work together. We're lacking a lot still to achieve that." – Oswaldo, Community Yachak

> "For me Interculturality is that both are functioning respecting and valuing each other mutually, that they work mutually with what each knows best. If the patient decides to go with the midwives, they need to let the midwives work in their way. That's what happens here, the midwives care for the patients and the doctors do the evaluation: weight, length, screenings. Those are complimentary things, that's how it should work large-scale throughout the country." – Pablo, AMUPAKIN socio

As all of the traditional practitioners described, biomedical and traditional medical providers alike have their own specialties from their situated knowledges and experiences. For them, Interculturality in health is truly achieved when providers see each other as equals, each using their specific skills to best meet the needs of the patient. In this model, the knowledge of traditional practitioners and biomedical providers is equally (or nearly) authoritative.

In reality, the experience was heavily one-sided where traditional practitioners and their methods were either ignored or rejected by biomedical providers. Although all traditional practitioners mentioned this to varying degrees, the midwives of AMUPAKIN were directly faced with conflicts of authoritative knowledge in their partnerships with biomedical institutions:

> "When the project started with the Red Cross, the MSP doctors kept saying, 'the midwives have to pay attention to what we have to say'. That the doctors have to care for the patient first, and will decide how the birth has to be managed, in what position. We said, 'No we don't want that, if you want it that way go work at the hospital. We're not here so the doctors can just boss us around. If they want to be here, the doctors need to listen to us and do it how we want.'" – María Fernanda, AMUPAKIN midwife

> "If the doctors valued us, I think it would be good. When they don't value us they just say, 'Don't do that! Don't give her that [tea]! Don't touch her!' So there's no help with the midwives there in that situation. I think having the doctors with us like that makes us afraid." – Asunción, AMUPAKIN midwife

For these midwives, the value of their own expertise was negated by doctors who demanded decision making power over patient care.

During the initial stages of the project with the Red Cross (circa 2005), the AMUPAKIN midwives were able to leverage their position as grantees to shape the project. This included excluding MSP doctors from working in the clinic after the confrontations described above. However, their later partnership with the MSP in 2011 meant the midwives often found themselves under the authority of the doctors, who both filed the "official" patient records and were held liable for adverse outcomes (see Chapter 4). As both the obstetrician and midwives noted, the doctors openly threatened to sign off legal responsibility for patient care in situations where they disagreed. This placed the midwives in significant risk, as they had no legal or institutional backing to support their knowledge and also created distrust with the patient. Several community midwives (not affiliated with MSP services) hoped that certification through the APKAM Manual would help make their knowledge more authoritative:

> "My hope is, if I go to all the trainings and do the tests with the doctors, they'll give me that credential. Then I'm recognized like a doctor in the clinic. If I'm taking a woman to the hospital and she dies on the way, then we all have the responsibility to talk about the details of the case and the doctors and nurses would help me." – Maruja, community midwife.

However, the association midwives I talked with in AMUPAKIN and Cotacachi were doubtful this credential would be treated any differently than the many printed certificates they had received from past traditional birth attendant trainings from the MSP and NGOs. Martha, the president of the Cotacachi midwives' association, noted their organization refused to work with the MSP after midwives in the neighboring city of Otavalo were made to clean rather than manage births in the famous Intercultural Birth room at that hospital. As several sources have noted, doctors at that hospital actively resisted midwife management of births, making them clean or serve as nursing assistants rather than practitioners in their own right (Gallegos, Watersb et al. 2017, Llamas and Mayhew 2018; interviews with participants 2013).

As other studies of traditional midwifery have noted, the assertion of biomedical knowledge as authoritative has also challenged and changed practices used by midwives even when they work independently in communities (Jordan 1997, Towghi 2004, Sibley and Sipe 2006). In my discussions and observations with midwives, these changes were often made to provide antiseptic care such as covering the floor/bed with plastic, wearing gloves, and cutting the umbilical cord with a new razor blade. However, the midwives at AMUPAKIN challenged the complete replacement of culturally significant practices. For cutting the umbilical cord, for example, they preferred to use the traditional implement of freshly broken bamboo. However, to comply with hygiene standards they pre-cut, sterilized, and wrapped bamboo for use during births. As with the debate over the use of Pitocin when doctors were present, the midwives actively challenged and negotiated what traditional methods could and should be within ever evolving standards of care. While the policies for culturally adequate birth, PLPPI, and the articulation of midwives allow the use of traditional methods, they give doctors the authority to determine which practices are harmful or beneficial. As the experiences of the AMUPAKIN midwives highlight, this ignores the need for structured relationships that allow for mutual negotiation and creative solutions to continue traditional practices in ever evolving standards of care.

Despite the challenges of institutionalized medical pluralism, the majority of the traditional practitioners I interviewed felt that integrating traditional and biomedical services in the same clinic was the best way of achieving Intercultural Health[72]:

> "It would be really beautiful, to have a house where we could all work. Like the yachaks, midwives, sobadores. If there was a place for us to work with the doctors, we'd each come with our medicines, have an exam room to work in. It would be great to be all together like that." – Oswaldo, community yachak

For them, this integrated form of care could fulfill several necessary components for a relational politics of intercultural health. First, it would facilitate referrals and trust between providers. Second, it would ensure continued access to traditional medicines given changes in Runa communities. Third, it would be the clearest demonstration of accepting the work of traditional practitioners as valid medical practice:

> "In my point of view, that idea of Interculturality that the government says, theres power. If they don't have us in the hospitals or clinics they're saying 'interculturalidad' for no reason."- Cora, AMUPAKIN midwife

As Cora describes, the lack of formal integration of traditional practitioners was viewed as proof that Intercultural Health policies did not actually promote or support traditional medicines. As many traditional practitioners and Napo Runa community members highlighted, it is not just the practices that make *sacha ambi* function, but the practitioners with their situated knowledges and experiences. However, as discussed in previous chapters, the efforts to "rescue" specific practices

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[72] While I heard anecdotes of traditional practitioners (especially *yachaks*) who resisted integration and biomedical care in general, I did not encounter those viewpoints in my interviews. This may be due to sampling bias towards midwives (given the emphasis on birth policies) who were more heavily targeted by biomedical training campaigns.

such as medicinal gardens and birth positions did not include structures to build lasting relationships with traditional practitioners who could guide their proper use.

As noted in Chapter 3, the prioritization of maternal mortality in state biopolitics meant Intercultural Health policies made almost no attempt to address the work of *yachaks*, *sobadores*, and other traditional practitioners. However, all of my indigenous interlocutors (and mestizos with personal experiences of traditional and alternative medicines) felt that integrated clinics should include those practitioners as well. For them, this was an important component of ensuring access to traditional medicines in light of rapid knowledge loss across all forms of traditional practitioners, and would ensure the most holistic approach to care including spiritual healing.

Furthermore, practitioners and their family members felt the existing IH policies encouraged theft or appropriation of traditional practices to be altered and implemented solely by biomedical professionals. For this reason, several Napo yachaks and midwives refused to participate in an MSP book project[73] that collected life histories of traditional practitioners throughout Ecuador (interview with district IH coordinator, 2015). For midwives especially, the recent expansion of PLPPI births without integrated midwives represented a direct form theft:

> "We don't want to lose our tradition, our culture. The government hasn't done anything yet, just trainings. They just talk and talk, and take what you're doing and use it."- Maruja, community midwife.
>
> "They just want to use the names and the knowledge of the midwives and natural medicine. So they can say everything is equal in this country. But if they don't give preference to the midwives. And if they can't share care while they use their knowledge, their instruments, their materials, its not going to be equal, it will never be equal. I think it is taking advantage in a way, maybe even exploiting the midwives." – Pablo, AMUPAKIN socio

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[73] Titled "Historias de vida de hombres y mujeres de sabiduría de la medicina ancestral," published in 2016.

As several of the midwives described, they have participated in "mutual dialogues" many times as part of midwife certification programs. However, they feel these dialogues result in no noticeable changes to biomedical practice nor the creation of working relationships with community midwives. AMUPAKIN, for example, participated in workshops to develop the policies for Culturally Adequate Birth and APKAM Manual. However, the midwives commonly referred to these meetings as "trainings" where they ultimately had little input over the policy decisions that were made. Notably, neither AMUPAKIN nor community midwives outside of PLPPI service areas were directly informed of the recent implementation. They learned of the new rooms along with general community members at events such as the *Rendición de Cuentas.* As Pablo emphasizes, if the relationship and authoritative knowledge between traditional practitioners and biomedical providers are unequal, the policies will only reinforce processes of appropriation under the guise of inclusion. Thus, the MSP is seen as emphasizing an exchange of knowledge that is quantifiable and easily adapted to meet their biopolitical agendas, which inherently undermines the mutually reciprocal relationship traditional practitioners seek.

> As discussed in previous chapters, a significant point of friction in establishing an equal relationship is the remuneration of traditional practitioners who do become formally associated with the MSP. The legal structure of the MSP only permits payment of healthcare providers with degrees. However, as many Napo Runa community members and traditional practitioners emphasized, traditional practitioners have comparable experience, years of training, and community respect as biomedical doctors. For them, the payment of integrated traditional practitioners was a requisite of institutionalized medical pluralism for two critical reasons. First, it represented a formal recognition of traditional practitioners as medical providers, just as the work of biomedical doctors is compensated through their salaries:
>
> "The midwife should be recognized just like the doctor. It's not just because she's there for the nationalities, but because she is a doctor. She just doesn't have a degree."
> – Josefa, Runa community member
>
> "If they were going to work in a clinic, they need a salary, because their degree is in their heads. because they know what medicines are for which diseases. I think they

> should also be paid in state institutions. I would want that because a lot of times they're better than the doctors." – Raúl, Runa Community member

Both practitioners and community members agreed this pay did not have to equal that of a doctor, but that direct pay generally from the MSP as the state's primary biomedical institution was a critical material indicator of the value and practicality of traditional medicines.

Second, the remuneration of traditional practitioners was seen as a fundamental component for respecting their work and dignity as people living in the market economy. Just as with broader critiques of *Sumak Kawsay*, they critiqued the rhetoric of inclusive cultural politics without substantive support:

> "The government doesn't help, they don't offer work, don't offer pay (for midwives). But we need money to go anywhere and to buy anything. So *Sumak Kawsay* lacking. We don't earn anything from the births, we help out of love. We go as volunteers, and after the birth some families give us things, the ones who feel for us." – Rosita, Community midwife

> "We are humans, we need money for food, money for school. I tell the doctors, why don't you try working for free for a year. Wouldn't your husband complain? and your kids? I tell them, you come and do these trainings, but you're earning. And they say, 'no I'm just helping'. But that's a lie, you're earning a salary." – Maria Fernanda, AMUPAKIN midwife

The policies of the MSP left payment of midwives to traditional indigenous systems of "randi-randi" [Kichwa, reciprocal exchange] (MSP 2016). Although Napo Runa community members and practitioners valued those systems of exchange that formed a critical component of *alli kawsana,* they critiqued the notion of romanticized and static indigenous economic relationships that were perpetuated by these policies. In the past, midwives and *yachaks* could be well compensated through these exchanges. As godmothers, for example, midwives would be gifted large amounts of food at the weddings of the babies they delivered. However, the stresses of market integration meant few families could afford traditional weddings or provide gifts to large numbers of godparents. As community economics and networks of care shifted, the work of a midwife or yachak was becoming less tenable as an occupation.

For members of AMUPAKIN, this point of contention was not only hypothetical, but lived experience. As noted in previous chapters, they asked each new district director to sign an agreement with the association that would offer remunerations for completed midwifery shift and/or rent for the use of the association buildings and furniture. During my work with them, they attempted to circumvent local politics during President Correa's visit to Tena for his weekly national address, the *sabatina*. During the private events before the *sabatina,* the midwives attempted to speak with the president directly, but were ultimately unsuccessful as he was quickly ushered between groups for photos. However, part of Citizens' Revolution reforms for participatory democracy and accountability, each sabatina included a large tent where attendees could file formal petitions and complaints with the government. The midwives filed a petition there, which was given a tracking number. The petition was forwarded to the national IH office, and eventually Dr. Juan, a national IH policy writer came to meet with the midwives in person. Although Dr. Juan later told me he personally felt integrated midwives should be remunerated (see Chapter 3), as a representative of the MSP he could only offer material supplies such as midwifery kits and rubber boots.

While I was impressed by how well the systems of government accountability functioned, the midwives highlighted how the existing structural inequalities between traditional and biomedicine remained despite the increased responsiveness of the state. As Pablo recounted:

> They're going to pay the doctors, but with the midwives it'll just be that she gets her little chicken or backpack. That's what the doctor said, **only products as a form a payment**. **But that's what happened in the communities BEFORE [emphasis original]**. But now the midwives are organizing like this association here, and its because they **want to do something for their families and their children NOW**.

> With that logic, there's no common sense in what the MSP is doing." – Pablo, AMUPAKIN socio

This quote expresses what many of my indigenous interlocutors (be it biomedical professionals, traditional practitioners, or community members) felt was a fundamental disagreement over what it meant to revitalize traditional medicines. As discussed in Chapter 3, MSP policy makers argued over how to articulate traditional practitioners without impacting the authenticity of their practice. Whether they attempted to shield traditional practitioners from institutional biopolitics or transition to more "universal" biomedical reforms, the effect was to relegate traditional medicines to a reified notion of the "community" . However, my indigenous interlocuters emphasized that the purpose of Intercultural Health should be the adaptation and advancement of traditional medicines and practitioners within the increasing market economy and obligations of *Buen Vivir*. Likewise, money was increasingly necessary to achieve *alli kawsana* and other traditional forms of exchange[74]. As the quote describes, the MSP's Intercultural Health policies create a logical fallacy of claiming to revitalize traditional medicines while preventing them from adapting to the lifestyle created by the biopolitical agendas of the same institution.

For AMUPAKIN in particular, the goal of the organization was to establish a way to legitimize traditional midwifery and traditional knowledge as a source of monetary income:

> "We say, when I get old and die I want to pass it my knowledge. But what will our kids have? If there's no income it will be forgotten. But with some sort of income, then you can do it. That was our idea for the project and the partnership with the MSP."- Cora, AMUPAKIN midwife

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[74] This even includes traditional forms of knowledge transfer, such as passing on *paju*. As one midwife described, she was only able to earn a handful of *powers/skills* because most *pajuyuk* now expected money in return. Likewise, a yachak hoped intercultural policies could provide grants to fund trips from shamans to travel and learn more skills.

For them, the only way traditional knowledge and values could evolve and be passed on was to incorporate them in the market economy. While they fought to have this dream realized through the Red Cross and the MSP, they also sought out other opportunities through cultural events, tourism, and NGO projects.

For local institutions and politicians especially, traditional practitioner associations present a convenient source of cultural "legitimacy" and flair to public events by hiring them to perform healing rituals or demonstrations of *Ruku Kawsay.* Through these relationships, some traditional practitioners have become important figures in cultural revitalization efforts as well. This role of cultural performance has also been reinforced by policies supporting eco and entho-tourism in the context of a "post-petroleum economic model" for achieveing *Buen Vivir"* (SENPLADES 2009). During my research AMUPAKIN and CYRAE were regularly hired to participate in public events to perform ritual cleanings, perform demonstrations, and provide performative *kamachina.*

These activities had become a virtual pre-requisite for any public event even moderately related to the indigenous population of Napo. For example, I accompanied the midwives as they participated in these activities during the Jumandy Festival, and events for women's rights, ethnotourism, and environmental protection (see figure 3). As with the presidential visit, the midwives used these opportunities to advise local and national leaders on how to value indigenous lifeways in their political positions. As I heard from several community leaders, AMUPAKIN had become an important actor in cultural revitalization efforts as they intentionally incorporated the most authentic forms of traditional practice in their events. This included catering events with only traditional forest foods, performing *uchu churana* (rather than mimicking), and only wearing loose fitting traditional clothing rather than tightly tailored versions common amongst the younger generation. Likewise, the association's dedication to traditional knowledge has made them popular amongst NGOs and tourist groups. Examples included funding from the GIZ for sustainable agricultural production of medicinal plants, a grant for collecting stories of Runa relationships with the forest, and receiving volun-tourists from the USA who helped manage social media accounts and apply for international funding. Through these relationships they have been able to establish networks through which they can access additional income and political influence with local authorities. As the founder of AMUPAKIN explained to me, this emphasis on cultural authenticity was an intentional strategy for gaining political access. For this reason, midwives were fined for not wearing traditional clothing during their shifts or at public events. In this way, they use their value as cultural symbols to attempt to effect change in the relational politics of the state and to also create new economies to allow *ruku Kawsay* to evolve.

However, participating in these multiple networks meant traditional medical organizations like AMUPAKIN had to negotiate their roles as cultural symbols and medical providers. On one hand, participating in lengthy public events our tourist experiences limited their availability to see patients, who typically arrived without notice. On the other hand, participation in these events often favored younger midwives and socios who had additional training in ethnotourism, catering, and event planning. As tourism and events provided the most consistent forms of income, this meant younger socios learned little about traditional midwifery or *sacha ambi;* but a lot about how to tailor events for tourists and public spectators. While the members of AMUPAKIN valued the economic and political opportunities these activities provided, they resented how their role as cultural symbols was valued more highly by local authorities and institutions than their skills as medical practitioners. As Maria Fernanda, a founding member of AMUPAKIN noted, “they see us as simple objects they can take pictures of to take advantage.” Again, state policies supporting ethnotourism and displays of cultural inclusion were seen to reinforce cosmetic forms of recognition while ignoring more formal relationships upon which traditional medicines could evolve and continue as legitimate forms of medical practice.

5.2.3 Subjectivities of Traditional Medical Practitioners

For traditional practitioners and Napo Runa community members, traditional practitioners played multiple roles essential to maintaining a Good Life, including: advisors of proper behavior, skilled medical practitioners, and guardians of traditional knowledge and values. However, as noted in previous sections, they felt these roles were not appropriately valued by MSP policies. For traditional practitioners, the decision to continue practicing often came at a high personal cost. None of the practitioners I interviewed were able to support their families from their earnings (monetary or material) as *yachaks* or midwives. Community practitioners were able to more readily balance their time between productive tasks, short-term employment, and medical work. However, association members expected to complete scheduled shifts often found themselves spending time waiting for events or patients without earning any money:

> “My husband and kids get mad at me for spending so much time here, not earning anything. When our husbands get really mad sometimes they hit us. I’ve done all kinds of things to earn something. Washing the doctors’ clothes, cooking their lunches. But its about giving value to our way of life.” – Cora, AMUPAKIN midwife

> “We keep the Kichwa way of life going however we need to, no matter how hard it is. Even if we don’t earn anything.” – Hortencia, AMUPAKIN midwife

For Cora and Hortencia, for example, they felt their time at AMUPAKIN had negatively impacted their families. Cora, for example, felt that her daughter became a teen mother because she was not able to keep a close watch over her at home. Likewise, Hortencia struggled with caring for her elderly husband while meeting her shift requirements. These challenges were the primary reason why the membership dwindled from roughly 60 midwives at height of the Red Cross era (when midwives were given modest remunerations for completing shifts) to only 13 during the research period. Yet, for the remaining members of AMUPAKIN, the importance of maintaining Napo Runa culture was worth these forms of personal sacrifice.

For the members of AMUPAKIN in particular, the partnership with the MSP also demonstrated the importance of close personal relationships with local authorities and biomedical staff to implement more equitable forms of intercultural practice. While yachaks and midwives were generally hopeful of the potential of recent IH policies to create integrated forms of care, the midwives at AMUPAKIN were apprehensive. While they had experienced mutually supportive and beneficial relationships with some of the clinic doctors and district directors, they knew these relationships were hard-won and fleeting:

> “The first obstetrician was firm that she cared for patients first, and she decided whether the patient could see the midwives. But the midwives called a meeting and said its the patient who decides, and you can see the patient with us. But then she would order the midwives around, and they said they wouldn’t come anymore if they were going to be treated like nurses. So they finally said they would work together. Talking like that, it got better each time. But then a new obstetrician came, and it started all over again.”- Gladys, AMUPAKIN midwife

As the midwives recognized, the ability to establish their knowledge as authoritative practice was largely dependent on their interpersonal relationships with biomedical providers. These discussions were often challenging, particularly given doctors’ lack of knowledge of traditional practices and verticial birth more generally. However, the midwives also acknowledged they took for granted the precarious situation the doctors found themselves in, as described in Chapter 4. These situated knowledges and positions of power were only remedied through consistent interaction and dialogue. However, the structure of MSP contracts inherently undermined these types of relationships.

Likewise, the members of AMUPAKIN noted the high turn-over of district directors severely impacted the ability to formalize the relationship between the association and the MSP:

> "The original director was really supportive, it was his idea to create a partnership. But he was removed after 3 months. The next director came and wanted to end it, but then she was removed too. Then came another director who was indigenous that we supported, but after everything she said she couldn't sign the agreement either. Every time they change directors, some say yes and some say no, but they never sign. Even though this new director is trying to figure something out, next year there will be another one and he'll say no and it just keeps going." – Paulina, AMUPAKIN midwife and MSP Staff

As noted in Chapter 4, district directors had the primary authority over integrated clinics such as AMUPAKIN and the clinic in Loreto. When directors supported the partnership, they had the power and authority to make clinic doctors comply with expectations of shared care and respectful treatment of the midwives. As Llamas notes in her study of the Otavalo Hospital, the support of directors and upper level management was critical to the compliance of biomedical staff who largely resisted the integration of midwives in birth management. However, as Paulina describes, the frequent turnover of local administrators made those most critical relationships nearly impossible to maintain. By the end of the research period, 4 years after the partnership between AMUPAKIN and the MSP began, the midwives had contended with 3 different Zonal Coordinators and 7 different district directors.

These subjective experiences of traditional practitioners, and especially the members of AMUPAKIN, again highlight the importance of relational politics to Interculturality. For one, the lack of national standards for integrated care meant each director and doctor determined how to apply Interculturality as they saw fit. While this disillusioned many of the midwives to the notion of Interculturality in health, they still felt it was possible if conditions were equitable:

> "It is possible to have both medicines working together. But it all depends on the laws. If the law doesn't have that common benefit, then it will never work no matter how

> much they want to apply it. Because there will a benefit for only one sector. But if the law is made for both worlds, then it will work perfectly." – Pablo, AMUPAKIN socio

Furthermore, the contract structures and political context that create high turnover of biomedical professionals (see Chapter 4) makes it impossible to establish the trust and relatability needed to challenge existing hierarchies within biomedical care settings. As they argue, if traditional practitioners are to support the goals of *Buen Vivir*, they must be treated as partners throughout the entire process.

5.3 Discussion

In this chapter I have examined how Intercultural Health policies are experienced and viewed by traditional medical practitioners. In particular, I have outlined the ways they interpret and challenge the affirmative biopolitics of *Buen Vivir* and Interculturality in their roles as medical providers, community experts, and cultural symbols of markedly indigenous ways of life. Although traditional practitioners and Napo Runa community members support Intercultural Health initiatives, they question the ways current policies are implemented and the ultimate goals they are meant to achieve. For them, the biopolitical goals of *Buen Vivir* prioritized by the state are important, but inappropriate as long achieving them undermines mutual relationships of care that value indigenous ways of life. They felt the prioritization of biomedicine in achieving the biopolitical goals of the state overlooked past and potential contributions of traditional medical practitioners in mitigating multiple forms of risk, and also ignored the ways policies effectively limited patient choice in care. Likewise, they felt piecemeal recognition of traditional medical practices would never result in meaningful revitalization of traditional medicines. Rather than reject the biopolitical agenda of the state, they sought ways to solidify their roles within it, and to emphasize a relational politics of Interculturality that was truly equal and mutually beneficial.

These perspectives of traditional practitioners and Napo Runa community members highlight existing tensions among the policy makers and biomedical professionals in the previous chapters. Much like indigenous activists and proponents of Holistic discourses of Interculturality, traditional practitioners argued for a more radical form of Interculturality that would significantly challenge biomedicine as the arbiter of authoritative knowledge in patient care. Although they did not invoke the radical forms of plurinationality present in the indigenous movement, they did argue for larger degree of self-determination in policy design and implementation. Like Holistic policy stakeholders and more supportive biomedical professionals, they argued that Intercultural Health should not only promote traditional practices but also guarantee access to traditional treatments and practitioners. Furthermore, they recognized the precarity of their relationship with the administrators and providers who mediated their relationship with MSP. Despite these challenges, however, they argued that formal institutionalized medical pluralism presented a critical opportunity to adapt traditional medicines to the market economy and obligations of *Buen Vivir*.

As relative outsiders to the public health institutions of the state, the experiences of traditional practitioners present a different perspective of the 4 Components of Affirmative biopolitics. Unlike local biomedical providers, traditional practitioners engaged in broad **networks of change** including local governments, NGOs, international tourism, and relationships with state institutions such as the MSP. They used these relationships to negotiate their roles as guardians of traditional knowledge and medical practitioners in the ever changing contexts of life in Napo Runa communities. As such, they attempted to create their own paths of incorporating a **plurality of lifeways** that could achieve a Good Life under their own terms, and make it possible for others.

While they acknowledge the **political and structural adjustment** taking place through intercultural policies, they felt the prioritization of pre-existing indicators overshadowed a more relational politics (and biopolitics) that would support meaningful intercultural partnerships. They welcomed and took advantage of new structures of **participatory governance,** but were disillusioned by the minimal impact their voices made in changing pre-existing relationships of power and authority. Instead, they sought consistent, though challenging, relationships where those relationships could be negotiated and redefined.

These findings build upon studies of birth and state relationships with traditional birth attendants. As Pigg notes, institutional training of traditional practitioners inherently reifies notions of a static cultural other with clearly defined practices to be accepted and changed to meet the needs of biomedical agendas (Pigg 1997). Likewise, work inspired by Jordan's theory of Authoritative Knowledge highlights the ways differential power and situated experiences between biomedical providers, patients, and traditional birth attendants create conflict over what is considered appropriate care (Davis-Floyd Carolyn Fishel 1997). This extends to a broader critique of biomedical birth as both technocratic (Davis-Floyd 2004) and abusive (Brandão, Cañadas et al. 2018), while ignoring the evidence-based benefits of common midwifery practices (Johnson 1997). My research builds upon these studies by examining the ways in which biopolitical mechanisms and institutional structures shape these negotiations of authoritative knowledge. As Jordan and many other anthropologists have argued, formal integration of traditional medical practitioners and biomedical providers requires dialogic relationships that develop consensus over care (Jordan 1997, Aguirre Fonseca 2007, Menéndez 2016). However, as my research shows, creating the policies and working relationships necessary to achieve that kind of dialogue is no easy task. Beyond creating the opportunity for dialogue, systems must enable and reinforce continued relationships in ways that benefit all parties and challenge existing hierarchies.

Other work on institutionalized medical pluralism has highlighted the ways integration of traditional practices create “hierarchies of legitimacy” between unrecognized practitioners, those who are recognized, and the biomedical institutions who maintain ultimate authority (Lock 1990, Lambert 1997, Ferzacca 2003). Several studies have examined how the institutionalization of traditional practitioners ultimately enables broader forms of biopolitical surveillance and control over and through traditional medicines (Ferzacca 2003, Boccara 2007, Nading 2013). Although these forces were also at play in Ecuador, I argue against a pure dichotomy of traditional practitioners versus the biopolitical controls of the state. Rather, as my own interlocutors described, surveillance and enforcement measures where useful and valuable when the perspectives of and impacts on marginalized communities were taken into account. Rather than resist biopolitical controls entirely, traditional practitioners demanded the integration of relational politics within them.

Finally, the critiques of *Buen Vivir* and Interculturality among traditional practitioners highlights debates over meaningful inclusion in politics of recognition. While many authors have emphasized the importance of political participation and the acceptance of alterity, traditional medical practitioners and indigenous community members also underscored the importance of economic viability. As demonstrated throughout these chapters, the battle over remunerations for traditional practitioners gives further proof to the assertion that politics of recognition are ineffective unless they involve inclusive democratic AND market participation (Kymlicka 2013).

6.0 Chapter 6: Conclusions & Future Directions

I have presented an analysis and evaluation of *Buen Vivir* and Interculturality as real-world examples of policies of affirmative biopolitics in action. Using Intercultural Health policies as the central point of analysis, I have examined the varied roles and perspectives of the primary actors involved in the design and implementation of these policies: activists and state policy makers, local public health administrators and biomedical providers, and traditional medical practitioners. To guide this analysis, I have proposed a new framework for studying and comparing affirmative biopolitics. In doing so, I have highlighted how complex negotiations between radical forms of integration/participation and biopolitical priorities of the state occur at all levels of the policy process- questioning simple dichotomies between an exclusionary governmentality of the state and radical resistance of outsiders. I have demonstrated how shifts towards affirmative politics and institutional medical pluralism are fundamentally shaped by the biopolitical mechanisms that standardize, evaluate and enforce state constructions of the Good Life.

In this chapter, I will discuss these findings through the four components of affirmative biopolitics, and their implications for studies of biopolitics, politics of recognition, and medical pluralism and birth. Finally, I outline important changes in Ecuadorian politics and Intercultural Health policies that have taken place since the research period ended in 2016. In doing so, I both underscore the importance of understanding affirmative biopolitics as an iterative process, and propose additional directions for further research.

6.1 Intercultural Health and the Affirmative Biopolitics of Buen Vivir

I have proposed that affirmative biopolitics are defined by their incorporation of 4 key components: broad networks of change, incorporation of a plurality of lifeways, participatory governance, and adjustment of existing institutional structures and biopolitical mechanisms. I argue the reforms under the *Buen Vivir* development plan and the Citizens' Revolution made significant strides in all of these components, albeit to varying degrees of success and sustainability. This was particularly evident in the dramatic transformation of the universal healthcare system and its incorporation of Intercultural Health policies. However, the experiences and impacts of those four components varied substantially based on actors' roles in the biopolitics of the state, and their situated authority and power within those roles.

Networks of change were critical to the development and nature of Intercultural Health policies in Ecuador. Initially a radical proposal from the indigenous rights movement, the involvement of birth activists and international health development organizations compelled significant affirmative changes, but also created overlapping and sometimes conflicting priorities for reform. This, in turn, both supported and complicated the role of policy makers in the national Intercultural Health office, who had to negotiate those conflicts to establish new standards while still supporting the primary biopolitical objectives of the state. In contrast, local MSP administrators and biomedical professionals had little connection to these broad networks of change, and their professional precarity discouraged forms of resistance or activism. Traditional medical practitioners, especially members of associations, participated in extensive local and international networks. In some contexts, this enabled direct resistance of imposed reforms, but most commonly created additional avenues through which they could reinforce their roles as cultural custodians and gain access to material resources not available through the MSP.

While the state discourses of Interculturality and *Buen Vivir* were explicit in their inclusion of a **plurality of lifeways**, the meaning of that inclusion was a point of debate at all levels of IH policy implementation. In their efforts to develop laws, standards of practice, and reporting requirements, politicians and law makers highlighted the tension caused by competing rights discourses that had been loosely united in activism for IH policies, particularly for birth. On one hand were the rights to plurinationality and cultural difference from the indigenous rights movement. On the other hand were the rights to universal biomedical care from the human rights movement, and rights to respectful care from humanized birth activism. These tensions combined in interesting ways to create a conflict between the right to cultural difference and the right to choice, and also the potential impact of biopolitical measures on degrading traditional medicines versus revitalizing them.

While some of these conflicts were felt by more radical biomedical professionals in local health services, those professionals were distanced from the rights-based discourses advocated by networks of change. Instead, they prioritized what Interculturality meant in the patient-provider relationship and community-clinic relationship. For them, the primary (and most sanctioned) form of inclusion was respectful and equal treatment of patients regardless of their ethnicity or medical itineraries. Traditional medical practitioners, however, questioned whether the affirmative biopolitics of the state truly reflected inclusion of alternate lifeways such as *Alli Kawsana*, as it limited their ability to live a comfortable life on their own terms. For them, inclusion was not about recognition, but about creating spaces where authoritative knowledge could be negotiated so that *Ruku Kawsay* could be adapted to new contexts and truly gain biolegitimacy. In this way, their perspective was more uniformly aligned with the indigenous movement's original proposal for Interculturality, although it did not extend as far as radical plurinationality.

Reforms towards **participatory governance** were featured in all levels of IH policy design and implementation, although it did not always foster the equal and transformative dialogues sought by more radical proponents of Interculturality. National requirements for transparency and accountability in government institutions had created important spaces where the implementation of IH policies (and related healthcare reforms) could be monitored and demanded by average citizens, particularly through formal complaint systems. Within the national IH office, community participation had become a component in the new policies, both for input in design and as a standard of practice (e.g. local health committees, involvement of traditional practitioners in "speaking maps"). The prioritization of right-based discourses was translated into purposeful promulgation of patients' rights to the new forms of care established by IH policies, largely through local healthcare services. While this fostered an increased sense of control over local services, it also fostered a rhetoric of co-responsibility that ultimately reinforced biomedicine as the sole provider of the Good Life. For birth in particular, limited access to both PLPPI centers and non-MSP care alternatives questioned whether those rights existed in practice. Furthermore, community members and traditional medical practitioners felt this improved access to political structures of enforcement did not necessarily increase their power or authority in making decisions over what biomedical care should look like. This was especially true of traditional practitioners, who inserted themselves in these participatory structures, only to find it did little to change the unequal and authoritative relationship with the MSP, nor to challenge the policies they were supposedly involved in making.

The governmental reforms of the constitution and *Buen Vivir* development plan did usher in significant **adjustments to institutional structures and politics** of health. Perhaps most importantly, the emphasis on measurable progress towards biopolitical agendas dramatically shaped the design of Intercultural Health policies. Within the national IH office, this created conflicts over how to evaluate and quantify Interculturality, which encouraged basic measures of materials and completion of certain activities. This belied internal tensions over whether standards should be universal or flexible to local needs, and whether the state should impose standards over traditional practitioners. Attempts were made at making relational indicators, including patient satisfaction and counter-referral rates, which were included based on the participation of traditional practitioners and indigenous organizations. However, more "radical" reforms such as remuneration for midwives working within MSP institutions were consistently rejected by existing laws and bureaucratic processes that prioritized achieving the objectives of *Buen Vivir* over Interculturality itself.

Those priorities were clear in the expectations and reporting requirements of local healthcare services, who ultimately served as a point of surveillance and intervention to reinforce biomedicine as a means of achieving the *Buen Vivir* objectives. In doing so, the roles of TAPS and traditional practitioners were primarily to reinforce that system of surveillance. In the instances where administrators or biomedical providers developed more radical relationships with traditional practitioners, their impact was erased in the data that mattered to the state. Likewise, existing structural limitations (ex. funding, high turnover, rural-year system) made such relationships unlikely and short-lived. While Napo Runa Community members and traditional practitioners welcomed many of the adjustments that were occurring, they challenged the ways the biopolitics of the state ignored the impact of traditional practitioners in achieving the objectives of *Buen Vivir* and challenging biomedical practices that were now generally considered unethical. They argued Intercultural standards should include relational politics, rather than exclusive focus on externally chosen indicators of health.

Several themes emerge through comparisons across levels of IH policy implementation. First and foremost, affirmative biopolitics can never be as radical or utopic as the discourses that shape them. This stems in part from the reduction of noble but vague notions of “participation” and “rights” into monitorable and reportable data points. But also, transformative processes will always be limited because of their necessary engagement with the existing institutional structures and biopolitical measures they seek to change. Likewise, those who attempt to enact change both within and outside of institutions find themselves negotiating their own definition of affirmative reform in the context of their multiple roles of defining, enacting, and living the standards of biocitizenship. Just as Grove and Pugh state, “a radical actor in one arena might be reactionary in another” (2015). Second, rather than eschew biopolitical control altogether, radically minded actors sought new forms of biopolitics that truly established the biolegitimacy and continued viability of plural lifeways, although it was not clear what those measures would be. Finally, affirmative biopolitics (and the broader discourses for change behind them) are never cohesive in their intent, nor their impact.

This echoes Tully’s assertion that politics of recognition are an iterative and unstable process. As he notes, rather than search for the “just and stable form of recognition that will end the struggle” we should seek forms of democracy that enable politics of recognition to “be played freely from generation to generation, with as little domination as possible” (2001). My research raises additional questions for attempts to evaluate whether radical reforms have been achieved: Whose criteria is success judged upon? Whose perspective/experience is the most valid? How much change is enough to be considered “successful”? While the proposed framework of affirmative biopolitics does not pretend to answer these questions, it does provide critical points of analysis through which these challenges of governmental reform can be examined.

6.1.1 Implications for Theories of Biopolitics

The construction of *Buen Vivir* as a form of national development measured by specific indicators of wellbeing easily lends itself to biopolitical analysis. It is clear that the Good Life constructed by the Correa administration is one defined by integration in the market economy, institutional participation, formal education, and active prevention of illness. A good citizen, then, is one who works (especially in the formal economy), demands their rights, and meets their obligations of attending school and completing biomedical checkups/treatment as recommended. While other authors have argued these and similar forms of biocitizenship conflict with indigenous constructions of the Good Life (Smith-Oka 2013, Whitten and Whitten 2015, Uzendoski 2018), I argue the situation is more complex.

While it is clear that the biopolitical standards of *Buen Vivir* and even Interculturality reinforce expectations of mestizo/urban standards of living, it is not a simple division of state imposition versus indigenous resistance to *Buen Vivir*. As Uzendoski implies in his work in Napo Runa communities, the loss of sacred values of communal living, self-reliance, and ancestral knowledge are unlikely to be replaced by structures of biocitizenship that reinforce dependence on government services (Uzendoski 2018). However, as I have also shown, Napo Runa are actively negotiating their roles in those biopolitics, knowing full well that the idealized form of *Ruku Kawsay* is no longer tenable, nor completely desirable. Even though formal schooling prevents traditional forms of medical knowledge transfer, midwives and *yachaks* want to send their children to school so they can find work, gain knowledge, and support their families as traditional means of subsistence continue to erode. However, we should not ignore Uzendozki's implication that obligations of biocitizenship established through *Buen Vivir* are eroding traditional forms of well-being and creating dependency on state institutions (2018). While it could be argued state biopolitical constructs of the Good Life and local ideologies of a life well lived are different levels of analysis, the negotiations of the biopolitics of Intercultural Health policies demonstrate how traditional practitioners, activists, and policy makers attempt to shift state biopolitics towards those ideological goals.

In this way, my research contributes to calls for understanding the implications of a democratic biopolitics. As Siisiainen notes, the adoption of participatory governance in the rationality of biopolitics creates "grey areas" where it is difficult to distinguish between governmental institutions and NGOs, and between activism and administration (2016). This was evident in the case of indigenous lawmakers and policy makers, who worked within the government as a means to create new and more inclusive forms of governance. While their impact was limited, it underscores the argument that biopolitics can be challenged both outside of and within government institutions (Marsland and Prince 2012).

Some have argued that *Buen Vivir* and similar frameworks advocate moral politics of quality of life over the target-driven development politics (Escobar 2010; Fassin 2007; King, et al. 2009). However, I demonstrate how those constructs of the Good Life can likewise be reduced to target driven measures such as Maternal Mortality and biomedical service utilization rates. As my work and that of other medical anthropologists have noted, such targets remain sources of assimilation and control (Nichter 2008, Stevenson 2012, Smith-Oka 2013). Stevenson argues that this stems from the "biopolitical reductionism" where indicators inherently supersede cultural lifeways and values (2012). Through my analysis, I examine how attempts are made to correct this through the design of IH policies, especially the APKAM Manual that would enable patients to access traditional forms of care in a sanctioned environment. However, as IH policy makers and traditional practitioners noted, that same process of integration creates its own forms of reductionism as well. Furthermore, I argue against examining Intercultural Health as an example of biosociality based upon indigeneity (see Rabinow and Rose 2006). Rather than demand traditional medicines for indigenous communities based on their cultural difference, more radical proponents (indigenous and otherwise) demanded access to traditional medicines for everyone, as valid medical systems in their own right. Rather than seek accommodations for a specific group, they sought a shift in society writ-large.

In addition, I examine the role of biopolitics in a neo-socialist government based on significant spending in health and other social supports. Joining critiques of biopolitics as the result of neoliberal governance (Marsland and Prince 2012, Campbell and Sitze 2013, Kymlicka 2013, Prozorov 2016), I examine how even extensive systems of "care" established through the Correa reforms are likewise driven by biopolitics and an ethos of personal responsibility to utilize those systems. Rather than relegating individuals to expectations of self-care, the MSP emphasizes personal obligations as a co-responsibility with the state. Thus, it is the state's responsibility to provide free, accessible, respectful, and culturally appropriate biomedical services. But, it is the Citizens' responsibility to utilize those services, and the community's responsibility to monitor both their neighbor's and the state's fulfillment of those obligations. After years of significant political and economic upheaval, the affirmative biopolitics of *Buen Vivir* and Interculturality have solidified for many Ecuadorians that the state SHOULD and CAN create a better life for its citizens. While the changes were often limited and even undermined meaningful incorporation of plural lifeways, expectations of governance were noticeably changed.

6.1.2 Implications for Interculturality and Politics of Recognition

This research also highlights the importance of examining the biopolitical implications of politics of recognition (PoR) such as Interculturality. Scholars of Interculturality and PoR generally have noted the inherent tensions between the self-determination demanded by recognition, and maintaining the legitimacy and control of the state (Hale 2005, Kowal 2008, Escobar 2010, Martínez Novo 2014, Kotni 2016, Uzendoski 2018). Building upon the work of Kowal (2008), I highlight the ways in which biopolitical agendas form a critical mechanism through which these tensions are negotiated and enacted, as they define which forms of alterity are deemed beneficial or dangerous. Thus, in Ecuador we see how the biopolitical reforms of Intercultural Health open avenues for the use traditional medicines (and even home birth), insofar as the obligations of biocitizenship are also met. However, we also see how those inherently biomedical obligations are challenged and potential forms of more inclusive biopolitics are proposed. In this way, I argue against an analysis where political power is viewed as a zero-sum game between marginalized groups and the state (see also Kymlicka 2013). By examining the negotiation of Intercultural Health, we see how the prioritization of certain kinds of biopolitics create complex spaces of control, resistance, and change.

This is perhaps most clear in Intercultural Health discourses and policies related to birth. Although some government officials questioned (and ultimately prevented) the radical integration of indigenous groups and practitioners, integration of traditional medicines was still seen as necessary to achieve the objectives of *Buen Vivir*. This encouraged paternalistic views of saving indigenous health and knowledge through “remediable difference” (Kowal 2008), where certain birth practices (and herbal remedies) become recognized as forms of “sanitized alterity” to be promoted, celebrated, and co-opted without undermining the biopolitical objective. However, it also coexisted with more radical approaches that sought methods of practice and evaluation that could prevent co-optation and expand benefits beyond ethnic categories. Likewise, indigenous communities themselves continually negotiate which activities should be carried on or left behind, and in what forms.

It is important to note, however, that the nature and impact of affirmative biopolitical reforms is not coherent among the "revolutionary" policies of the Correa Administration. Intercultural Health policies likely present the most progressively radical and internally valued reforms, in contrast to related policy shifts in bilingual education and environmental protection. Analyzing policies of Intercultural Bilingual Education (EIB), Martinez Novo notes how discourses of *Buen Vivir* and Interculturality enabled "post-recognition racism" that celebrates dialogue and respect for the Other, but limits or undermines forms of participation to such a degree that denies them a real voice in shaping policy (2014, Martínez Novo and Shlossberg 2018). Building on that critique, Uzendoski examines how policies for prior informed consent of resource extraction reinforced Napo Runa communities as passive agents in supposedly participatory processes that ultimately confirm what the state (and industry) has already decided (Uzendoski 2018). Such critiques should not be ignored, as requirements for extraction consent and previous indigenous control of EIB were purposefully eroded throughout Correa's term in office. However, I argue Intercultural Health policies present an important counterpoint where affirmative change has remained intact.

The more radical nature of reforms in Intercultural Health is due in part to the nature of medical encounters. This point was succinctly put by Kuri, the indigenous MSP policy analyst (Chapter 3), "doctors are more intercultural than other sectors, because they have to care for and speak to people who are different. If they had a different kind of education they would be the vanguard of Interculturality." Furthermore, unlike EIB and prior informed consent, those same processes of doctor-patient care and respect had already become biopoliticized within the networks of change that spurred and shaped the implementation of Intercultural Health policies in Ecuador. The inclusion of humanized birth practices and patient satisfaction rates in international accreditation standards, for example, provided existing alternative measures that reinforced PLPPI policies, which then has the potential to expand the impact of the AKPAM Manual (to be implemented in all primary care PLPPI centers). Likewise, increased international focus on malpractice and obstetric violence meant that participatory/ accountability reforms such as complaint tracking were taken seriously within the MSP.

These comparisons highlight why the proposed four components of affirmative biopolitics are critical for analyzing politics of recognition. It is not just a matter of checking whether each component exists in some form, but how they support each other (or not) to create change. In Chile, for example the limited recognition of plural lifeways isolated Intercultural Health reforms to markedly indigenous regions (Aguirre Fonseca 2007, Kowalczyk 2013). Likewise, the lack of changes toward participatory governance enabled more paternalistic and coercive practices under IH policies in Peru and Mexico (Kotni 2016, Guerra-Reyes 2019). In Bolivia and Peru, Interculturality was also widely applied in national policy and supported substantially by networks of change. However, the lack of largescale political and structural adjustments to support Intercultural Health, and universal care more generally, made Interculturality a convenient cover for inadequate governmental services (Ramírez Hita 2014, Guerra-Reyes 2019). In contrast, IH in Ecuador was implemented alongside a much broader system of reform that has attempted (although sometimes failed) to address multiple determinants of health and well-being such as housing and potable water. In all of these contexts however, the challenge of measuring and enforcing “mutual and equal dialogue” remains. As Guerra-Reyes also notes, policies based on such loosely defined dialogue are fragile and person-dependent (2019). Just as with IH in Ecuador, the policies do little to enforce this relational aspect, which limit the potential to challenge biomedicine consistently or sustainably.

6.1.3 Implications for Birth and Medical Pluralism

As a health-centered politics of recognition, analyzing the biopolitics of Intercultural Health policies in Ecuador also contributes to studies of medical pluralism and birth. Many studies have noted how expectations of biocitizenship and even IH policies erode traditional knowledge by shifting care towards biomedical clinics (Pigg 1997, Smith-Oka 2013, Guerra-Reyes 2019). In Ecuador, policy makers and traditional practitioners attempted to avoid such erasure by seeking forms of institutionalized medical pluralism. Although PLPPI policies largely emphasized the incorporation of indigenous *practices* over the incorporation of the *people* who are considered experts in their use, that effect of cultural erasure was challenged at multiple levels of implementation. This includes the development of the APKAM manual and the District Directors’ plan to create a midwife-led training center. But, as more radical proponents underscored, the lack of financial incentive and mutual management of integration ultimately has the same effect. In this way, integration can allow the government to say it is rescuing indigenous knowledge while it strengthens systems of surveillance and compliance toward biomedical care (Ferzacca 2003, Ramirez Hita 2009, Huayhua 2010).

Similarly, studies of institutional medical pluralism have noted how such forms of integration can biomedicalize traditional medicines (Bastien 1992, Craig 2011, Khalikova 2020). In the national IH office, MSP policy writers were actively trying to prevent such processes, largely by maintaining a degree of separation between traditional practitioners and the state. Likewise, more radical proponents of Interculturality sought ways in which to change biopolitical measures to count the contributions of traditional medicines to achieving biopolitical objectives outside of their integration with biomedicine.

Many scholars have highlighted how traditional practitioners and traditional birth attendants (TBAs) provide alternatives to biomedical care viewed as technocratic, violent, and oppressive (O'Neil 1989, Jordan 1997, Nichter 2006, Vega 2017). This was certainly true in Napo, but I also highlight ways in which traditional practitioners sought to directly confront those issues within the biomedical system. As Vega notes, the rise of humanized biomedical birth has been an important challenge to biomedical mistreatment, but has created new forms of stratified reproduction where the such care is supported when it occurs in expensive private hospitals but penalized when provided by TBAs (Vega 2017). While this was the case in Ecuador as well, the expansion of PLPPI rooms nationwide has given many lower-class women access to humanized birth. The APKAM Manual could also potentially broaden access to birth with traditional midwives if it is implemented with the intent in which it was created- to legitimize traditional practitioners within state institutions.

Similarly the involvement of activists and traditional practitioners in the development of Intercultural Health policies, and as policy makers has helped avoid many of the pitfalls of culturally appropriate care and professionalization of tradition medicines. Ecuadorian IH policies for example, have noticeably resisted “fact-file” approaches listing patient beliefs or “accepted” practices as seen elsewhere (Bastien 1992, Carpenter-Song, Schwallie et al. 2007, Ramirez Hita 2009, Guerra-Reyes 2019). Likewise, they have resisted imposing the same standards of biomedical practice and production on traditional practitioners that would facilitate institutional control over them. Nevertheless, any forms of integration will necessarily involve judgements over what practices and which practitioners are considered legitimate (Lambert 1997). In addition, this separation from institutionalization also removes TBAs from potential sources of income as preferences for birth care change. In this way, traditional practitioners in Ecuador can be understood as shifting the point of critique from one of determining cultural/medical authenticity to one of intellectual property: who has the right to earn from traditional knowledge and skills?

Many researchers of medical pluralism have posited situations of equality between medical system through lasting and formidable relationships between biomedical institutions and traditional practitioners (Bastien 1992, Jordan 1997, Alarcón M, Vidal H et al. 2003). However, others argue that the dominance of biomedicine will reinforce hierarchies of legitimacy even in situations of professionalization (Ferzacca 2003; Lambert 1997; Lock 1990). As I have shown with Intercultural Health policies, biomedical authority over the definitions of biocitizenship play a critical role in this process. While some practices and practitioners may excluded from being seen as incommensurable with biomedical ideologies (Ferzacca 2003, Khalikova 2020), I argue the ability of traditional medicines to contribute to the biopolitical agendas of the state are also an important consideration.

State prioritization of health indicators such as maternal mortality rates and population growth have been shown to encourage risk reduction/goal obtainment via any means necessary, justifying abusive or coercive practices (Castro 2004, Nichter 2008, Morgan 2019). In other countries, this is even true of Intercultural birth policies meant to provide more respectful care (Guerra-Reyes 2019). However, in Ecuador there has been a biopolitical shift towards counting and evaluating respectful care in addition to health indicators that (even out of luck or coincidence) have been associated with Interculturality. This has allowed biopolitical and structural adjustments that have reinforced Interculturality in health as a required standard of care. The care enforced by those new biopolitics is not equally accessible, nor does it address radical demands. However, it has fomented a significant shift within biomedicine from resisting traditional practices and beliefs, or viewing them as temporary tools in processes of assimilation. As many doctors described to me, Intercultural Health policies were not about changing women toward biomedical birth, but about changing biomedical birth toward women.

6.2 Are Intercultural Biopolitics Possible?

I argue that yes, intercultural biopolitics are possible but unlikely. Just as CONAIE proposed in its own Intercultural Health policy, this would involve creating participatory systems of policy development, implementation, monitoring and enforcement (CONAIE 1998). Work in community based participatory research, and indigenous evaluation more specifically, have demonstrated how such forms of participation and dialogue can create mutually meaningful and beneficial initiatives (LaFrance and Nichols 2008, NCCIH 2013, Cram 2018). They emphasize methods of data collection and evaluation must prioritize indigenous sources of knowledge and analysis, including oral histories, dream narratives, sensory experiences, and elder talking circles (LaFrance and Nichols 2008, Cram 2018). They also argue that interventions and their evaluation must serve to strengthen existing community capacities, create new capacities (as prioritized by the community), and ultimately support self-determination in health (NCCIH 2013, Cram 2018).

One such project at the Intercultural MSP clinic in Loreto used participatory methods with community members, traditional practitioners, biomedical staff, local government and NGO administrators to develop intercultural indicators for evaluation and continued management of IH programs. Notably, these heavily emphasize relational measures of provider-patient and clinic-community interaction (Arteaga, San Sebastián et al. 2012):

Table 5. Selected Proposed Indicators of IH[75]

DIMENSION	SUGGESTED INDICATORS
COMMUNICATION	• % of EAIS teams with access to interpreters • % of educational activities utilizing alternative forms of instruction (drama, video, miming, etc) • % of didactic material presented to all service communities in local languages • % of communities receiving messages supporting Kichwa culture
SERVICE PROVISION	• # of health centers aware of local traditional practitioners and their roles • # of bimonthly participatory planning meetings (min. = 6 annually) at each health center • # of health centers with culturally adequated spaces that influence patient satisfaction.
COMMUNITY INTEGRATION	• # of communities actively participating in the participatory planning meetings • # of communities with traditional practitioners participating in planning committees • % of health centers rated as effectively coordinating intramural and extramural activities with the community • # of health centers with maps of local health and social agents (including traditional practitioners and NGOs), created through community participation • % of communities that prepare traditional foods for EAIS teams per year • % participation of each community representative in planning and evaluation meetings
KNOWLEDGE EXCHANGE	• # of knowledge exchange meetings led by midwives and CHWs per year • % of personnel trained in culturally adequate birth by midwives • % of midwives satisfied during shifts at the clinic, reported quarterly • % of MSP personnel completing community participant observation, and observations of yachaks • % of clinics with traditional chagras and training in traditional nutritional knowledge

Interestingly, these indicators also include measures of co-responsibility, where indigenous communities are expected to demonstrate recognition of the work of MSP staff. Rather than emphasize service utilization, they emphasized the community's participation in planning, and establishing sociality through sharing of traditional foods. The project was supported by the

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[75] Selected and translated from the original list of indicators proposed in Arteaga, E. L., M. San Sebastián and A. Amores (2012). "Construcción participativa de indicadores de la implementación del modelo de salud intercultural del cantón Loreto, Ecuador." Saúde em Debate **36**: 402-413.. Indicators that were included in *Servicios Inclusivos* requirements (not implemented at the time of publishing) were excluded from the table above.

District Director of the MSP, and Subsecretariat of Health Governance, was intended to put these indicators into practice. However, sudden turnover of those MSP administrators ended the project. It is unclear whether the project influenced any of the standards included in the *Servicios Inclusivos* accreditation or the APKAM Manual.

Notwithstanding the limited application of the Loreto intercultural indicators, they reveal the possibilities of creating quantifiable measures of relational politics. However, the primary challenge of creating an intercultural biopolitics is scaling participatory and indigenous evaluation methods to levels of governance. New systems of “Nation to Nation” governance based on the United National Declaration on the Rights of Indigenous Peoples have begun to emerge more broadly (Kukutai and Taylor 2016, Bowman 2020). This includes increasing involvement of indigenous communities in the development of international biopolitical standards such as the Sustainable Development Goals[76] and measuring the attainment of ILO treaty for indigenous rights (Davis 2016), and recent governmental structures in Australia and New Zealand creating indigenous panels shaping which national health indicators are measured and how (Bishop 2016, Jelfs 2016). Likewise, indigenous researchers have argued for the creation of national indicators of well-being that incorporate indigenous forms of sociality instead of reifying nuclear family units (Snipp 2016). Such processes are difficult to achieve and maintain, and are often resisted for reasons of expediency and cost-effectiveness (Kukutai and Taylor 2016). However, the increased spread of these models indicates the continued efforts of networks of change to incorporate participatory governance and plural lifeways within the biopolitics of national governments.

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[76] Coincidentally, shortly after research ended the members of AMUPAKIN participated in research project investigating indigenous perspectives of the SDGs Bernis, C., A. Schwarz, C. Varea and J. Terán de Frutos (2017). "Parteras kichwa del Alto Napo (Ecuador): salud intercultural, partería tradicional y ODS." Revista española de desarrollo y cooperación **41**: 189-200.

6.3 Epilogue: Intercultural Health Post-Correa

Nearly six years have passed between data collection and the writing of this dissertation. In that time, significant changes have taken place in Ecuador that have impacted the affirmative biopolitical reforms ushered in under President Rafael Correa. In 2017, Correa fulfilled his constitutional term limits and was replaced by his Vice President, Lenín Moreno. Despite campaign promises, Moreno radically reversed many of the reforms of the Correa administration, including reversing controls over civil society and the judicial branch (Stuenkel 2019). Moreno also radically reduced social spending, in part, an attempt to reverse the increased reliance on loans from China and petroleum exports (CRS 2021). In 2020, Correa was convicted in absentia of aggravated bribery by the Ecuadorian National Court in a highly controversial trial.

After significant public protests over austerity measures in 2019, Moreno lost the 2021 election to center-right candidate Guillermo Lasso, who has promised a return to neoliberal economic models despite significant opposition from the National Assembly. Despite the charges against him, Correa attempted to run for Vice President in 2021 while in exile, using medical brigades as a key strategy in his campaign with Presidential Candidate Andrés Arauz to "return to the future" (El Universo 2021). With the further drop in oil prices during the COVID-19 pandemic, the country has entered into a severe economic depression (CRS 2021). While this has stalled and even reversed some of the reforms of the universal healthcare system, it has surprisingly reinvigorated ties with Pachakutik, with Lasso supporting its leader's bid for the presidency of the National Assembly (CRS 2021).

Despite these political and economic upheavals, both subsequent administrations have retained the rhetoric of Interculturality, *Buen Vivir* and the use of well-being indicators as part of national development plans (CNP 2017, SENPLADES 2021). The primary Intercultural Health initiatives discussed in this research have also continued. Despite subsequent reductions in funding, the constitutional right to free healthcare and the dramati improvement of public health infrastructure under Correa's administration seem to have established the relative independence of the MSP from the tumultuous shifts of Ecuadorian national politics. Subsequently, the importance of Intercultural approaches within the transformation of the MSP may have shielded Intercultural Health policies from current neoliberal reforms and the repeal of many protections for indigenous rights and civil society under Presidents Correa, Moreno, and Lasso.

Within MSP services, PLPPI birth has continued to expand, and all MSP hospitals are now required to implement it as part of ESAMYN accreditation. In 2018, PLPPI birth was available in 236 MSP health establishments (El Comercio 2018). This includes the hospital in Tena, which finally built a PLPPI room in 2019, with the first birth occurring in 2020. Notably, the hospital's social media promotion of the new room (see Figure 8) featured photos of the AMPUAKIN midwives in green scrubs touring the facility (HGJMVI 2019).

Figure 8. AMUPAKIN Tours Tena Hospital PLPPI Room

By 2019, the MSP claimed that 67% of all births within the MSP followed the mother's choice of birth position[77] (MSP 2019). The APKAM Manual was widely implemented, and by 2020 the

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[77] It is unclear how accurate this statistic is, as it includes vaginal, c-section, and "complicated" births.

MSP had articulated 1351 midwives (MSP 2020), including 27 midwives in the research district, ten of those members of AMUPAKIN (CZS2 2019). However, it remains unclear how that articulation is implemented in practice across MSP services.

After seven years of informal partnership, the midwives of AMUPAKIN demanded the closure of the MSP clinic P.S. AMUPAKIN in their buildings in 2018. This request came during the year-long process of formally articulating the midwives under the APKAM Manual. As the midwives explained to me, this decision came out of frustration over the local district's continued intransigence in signing a formal agreement that would provide either remunerations or rent for the use of their buildings. The frustration was only increased when their participation in the articulation process did nothing to change their partnership with the MSP (possibly because articulation was directed by the zonal rather than district office). The midwives hoped opening up building space could provide more opportunities for partnerships with other organizations. Limited travel during the COVID-19 pandemic severely reduced the association's income from tourism, but in 2022 they have launched a new revitalization campaign to expand their branding and voluntourism opportunities.

Under Lenin Moreno, the national IH office was once again upgraded to the level of Directorate within the MSP. In 2017, the MSP also signed an accord to co-develop policies with the *Instituto de Idiomas, Ciencias y Saberes Ancestrales (MSP 2017).* During Moreno's presidency, the IH Directorate published several more policies, including formal requirements for the *Servicios Inclusivos* and medical plant gardens. For the *Servicios Inclusivos*, 95% of clinic staff are required to receive training in Intercultural Health, and clinics must maintain a map of the articulated midwives within their service communities (MSP 2018). The new medicinal garden standards outline requirements for the participation of the local health committee, knowledge exchanges regarding plant use, and long-term maintenance of the gardens. Under these guidelines, nearly all of the gardens planted during the research period were deemed "demonstration gardens" and were required to implement the new standards (MSP 2017). Other new and significant policies included a plan for intercultural management of COVID 19 (MSP 2020), and a code of ethics for traditional medical practitioners (MSP 2020). As stated in the Code of Ethics, the purpose and design is not meant to impose state standards of practice on traditional practitioners, but to suggest mechanisms through which traditional practitioners and communities can regulate themselves to prevent charlatanism, articulate with alternative medicines, articulate "with dignity" to biomedicine, and manage malpractice (MSP 2020).

Despite cuts in public funding, the continued application of Intercultural Health measures after the Correa administration further demonstrate the importance of political and structural adjustment and participatory governance in establishing iterative (but incremental) affirmative change. While policies such as the APKAM Manual and ESAMYN accreditation continue to reinforce the application traditional midwifery practices in biomedical institutions, the lack of economic and biopolitical recognition of those midwives (and other traditional practitioners) demonstrates the limitations of affirmative biopolitical reforms in Ecuador.

6.3.1 Future Directions of Research

In this research I sought to understand the biopolitical implications of Interculturality in Health. Specifically, I argue that Intercultural Health policies in Ecuador represent a shift toward affirmative biopolitics under the reforms of President Rafael Correa and the *Buen Vivir* development plan that incorporated aspects of the indigenous right's movement's radical notion of Interculturality. In doing so, I propose that affirmative biopolitical change is an iterative process that requires an incorporation of plural lifeways, networks of change, participatory governance, and biopolitical and structural adjustments. Through analysis of the roles and discourses of policy makers, local biomedical professionals, and traditional medical practitioners, I have outlined the complex ways in which each of these components are understood, enacted, and negotiated across policy development and implementation. Although IH policies and state biopolitics at the time of research ultimately reinforced the status of biomedicine, they did create footholds for the creation of new forms of recognition and alternative biopolitics.

This study raises important questions for continued research. It is critical to understand how IH policies may be shaping (or not) negotiation of authoritative knowledge within health encounters, particularly given the large scale articulation of midwives through the APKAM Manual. As other studies of Intercultural Health have shown, it is very possible that forms of deriding home births and traditional midwifery, or of restricting the work and knowledge of midwives could continue in spite of this policy. It is also important to more fully examine the perspectives of shamans and other traditional practitioners such as herbalists and bonesetters who have been largely left out of MSP attempts to integrate traditional practices. Finally, further study should examine the long-term impacts of IH policies and universal healthcare on private forms of Intercultural Health. Despite being the initial models of Interculturality in health, programs such as Jambi Huasi, AMUPAKIN, and others have struggled to compete with free universal healthcare.

The proposed framework of affirmative biopolitics provides a tool through which other politics of recognition can be evaluated and compared. This could enable a more direct comparison of Intercultural Health policies across Latin America, which have had dramatically different results in program design and implementation despite similar radical rhetoric. Likewise, the framework could provide insights into the polemic policies of the Correa administration, which both increased some forms of social support and recognition while also increasing authoritarian control over many of those reforms. Such comparisons across policy sectors and national agendas could provide a better roadmap for how to meaningfully foster and sustain the evolution of affirmative biopolitics.

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