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Intercultural health in Ecuador: an asymmetrical and incomplete project

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ABSTRACT

Intimate connections between culture and health are complicated by various understandings of the human body, divergent beliefs about reality and place-bound theories about healing. Health care systems in various countries are modified with a goal of creating 'hybrid' structures that make room for traditional practices within a dominant Western model. But genuine intercultural health care is elusive. In Ecuador, a country with great cultural and geographic diversity, the culture-health spectrum is broad and bumpy. This is especially evident in health care politics, education and administration. A constitution adopted in 2008 aims for inclusivity and equality by incorporating indigenous concepts of the 'good life' and ideals of an intercultural society. These new values and perspectives should be reflected in economics, law, education and health care. But these concepts confront a racial, political and economic history that has delegitimized indigenous systems of knowledge and belief. This paper contrasts 'ideal' and 'real' intercultural health care using case studies of the Tsáchila, an indigenous group in coastal Ecuador. The conclusion is that 'ideal' intercultural health care, as reflected in medical school education and clinical practice, is a superficial attempt at dialogue and understanding between indigenous and western medicine. 'Real' intercultural health care involves a more profound level of mutual respect and cross-cultural understanding that aims for symmetry in patient–doctor relationships. Insights from medical anthropology guide the authors through a critical analysis that addresses interculturality as a political issue and a political struggle that the Tsáchilas – like other indigenous groups – are losing.

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Introduction

The filters through which illness and wellness are understood and enacted in Ecuador have multiple, interwoven layers. Indigenous knowledge systems, socioeconomic structures with roots reaching back into the colonial era and the technological and cultural influences of western medicine have produced a health system that is hybrid, complex and fluid. Traditional healing practices remain in both rural and urban areas, often alongside clinics and hospitals focusing exclusively on western medicine. More than three decades ago,

Kroeger (1982) analysed data from four Ecuadorian indigenous communities and concluded there was a 'conspicuous' preference for modern health care. But, as Finerman (1983) has pointed out, health and identity are intimately connected in many communities, a fact not always considered as healthcare is extended into more remote areas. In 2005, the United Nations Permanent Forum on Indigenous Issues, in a focus on health equity, called for better access to healthcare and a greater voice in decision-making for native peoples (Horton, 2006). Since then, a widespread indigenous movement, legalization of indigenous medicine and justice systems and valorisation of traditional healing through eco- and ethno-tourism has – to some degree – legitimised and popularised indigenous healing systems. Poverty has also contributed to the staying power of traditional medicine, as it generally is more affordable and accessible than western medicine. Regardless of the reason, many indigenous Ecuadorians and some *mestizos* (mixed European and indigenous ancestry), continue to rely on shamans, midwives, herbalists and other healers when they are ill.

The Ecuadorian government has responded to pressure for incorporation of traditional medicine into the Ministry of Public Health (MOPH) by legalizing it in the 2008 Constitution and creating the *Dirección Nacional de Salud Intercultural* (State Office of Intercultural Health) within the MOPH. The model as it has evolved in Ecuador aligns with Mignone's definition of intercultural health 'understood essentially as practices in health and health care that bridge Indigenous Medicine and Western Medicine, where both are considered as complementary. The basic premises are that of mutual respect, equal recognition of knowledge, willingness to interact and flexibility to change as a result of these interactions (Mignone, Bartlett, O'Neil, & Orchard, 2007).

This paper uses several case studies to examine the interface between the indigenous Tsáchila people of the Ecuadorian coast and western-trained medical personnel. As Lincoln, Liang, and Mackey (2015) and Torri (2012) have discovered in studies of the intercultural health model in Chile, there can be important disconnects between patient and provider in how 'intercultural' is interpreted and experienced. In a 2007 study of five cases of intercultural health practice in Latin America, Mignone et al. concluded that the 'relationship with personnel at the hospital level was not particularly positive, thus limiting the cultural appropriateness of services. The significant contribution of this paper is to explore this tension by identifying a contrast between 'ideal' (government-inspired model) and 'real' (meaningful cross-cultural interaction and mutual respect) intercultural health. Following a discussion of methodology, background on the Tsáchila is provided, along with key elements of their traditional beliefs and practices related to health. Following this are summaries of three case studies. Contrasts are then drawn between ideal and real intercultural health by reflecting on Tsáchila experiences at the Hesburgh Hospital in Santo Domingo, Ecuador. The conclusion is that 'real' intercultural health would involve symmetrical relations in which patients choose the elements of a therapeutic itinerary that is congruent with beliefs and practices, as described in the cases below. But in the opinion of the authors (three physicians and a medical anthropologist), this is currently the exception in most of Ecuador.

Methodology

The current study is based on qualitative research. Convenience sampling was used, along with participant observation in Tsáchila communities and interviews with informants.

These multiple data points allowed for triangulation of information to support key arguments, i.e. the authors' primary insights were confirmed across the three methodologies referred to above. An explicitly anthropological methodology was not developed at the start of the study, as the salient cultural information emerged from encounters between hospital personnel and Tsáchila patients. Rather, encounters between health care workers and patients from the Tsáchila community were analysed anthropologically 'after the fact,' as existing data, for relevant cultural information. The health care team consisted of three Ecuadorian general practitioners, three Ecuadorian family doctors and two Cuban specialists. Three of the doctors were men. All Ecuadorian doctors self-defined ethnically as *mestizos*. Three nurses were also part of the team, as were several 'cultural promoters' responsible for relations with various groups in the community. All of the above are associated with Hesburgh Hospital, a project of Andean Health and Development (Saludesa in Ecuador). A cultural anthropologist with extensive experience in cross-cultural health issues in Ecuador contributed insights from medical anthropology after the case studies were collected and analysed.

Case study interviews focused on a deeper understanding of the patient experience of 'becoming sick,' and were analysed through Moscovici's theory of social representations (Farr & Moscovici, 1984). This looks at the processes through which members of a group come to define and understand social objects of importance, allowing them to communicate in a meaningful way. Moscovici distinguished between the reified universe of science, and the consensual universe of social representation that emerges with the lay public. The distinction is particularly salient with regard to health, as epistemologies within these realms often have divergent histories. Later in the paper, these social representations are contrasted with conceptual categories in clinical medicine.

Since it opened in 2014, the hospital has collaborated with Tsáchila communities to improve health and healthcare delivery. This collaboration began with a project to produce baseline data about Tsáchila health. Qualitative data emerged from this collaboration. This part of the research project involved the cooperation of the Tsáchila government, through formal and informal means of communication and prior consultation with elders of the community. The Tsáchila governor issued a call to the community for participation in the health study, which was completed at the Hesburgh Hospital in Santo Domingo from June 15 to October 1 2014. At the start of the study, the purpose of the research was explained and consent forms were signed that allowed for collection of data related to personal pathology, vital signs, physical examinations and laboratory tests. Ultimately, 407 members of the community agreed to participate in the study. While the baseline health data provided information useful to Hesburgh Hospital, the qualitative data that emerged led to the reflections in this paper.

The Tsáchila: history

The Province of Santo Domingo, the contemporary home of the Tsáchila, is on the flanks of the western range of the Andes (see [Figure 1](#)). The city of the same name is about 130 km west of Quito and 120 km east of the Pacific Ocean. The Tsáchila live in eight communities around the city of Santo Domingo, which has grown substantially in recent decades to a current estimate of 450,000 (Domingo, 2015). The Tsáchila represent a small but slowly



Figure 1. Map of Ecuador Courtesy of the University of Texas Libraries, the University of Texas at Austin.

growing community. In 1986, Robalino (1989) reported a population of 1,403, while recent census data show nearly 2,700 Tsáchila in communities along roads connecting Santo Domingo with Quevedo to the south, Chone to the southwest and Quinindé to the north (Saltos & Vásquez, 2009).

The Tsáchila historically were referred to as the ‘Colorados,’ due to their application of a red paste from the achiote pod to their hair and skin. The Tsáchila appear to be descendants of several groups, particularly those referred to as the ‘Yumbos,’ with historical roots originally in Central America and Colombia, and later in the Andean highlands of Ecuador. Lippi (2004) hypothesised that after 800 AD the Yumbos separated from the Caranquis and Panzaleos in the highlands and went to live in the tropical forests of Pichincha. Salomon (1997) and Moreno (Ayala Mora, 1993) indicate that in the early colonial period large native groups existed that were referred to by colonial administrators as the Niguas, Yumbos and Tsáchilas. These groups traded from Esmeraldas on the Pacific coast to Cotacollao in the highlands and from Santo Domingo to Babahoyo on the coast, giving names to various rivers and villages in what are now the provinces of Cotopaxi, Los Ríos and Bolívar.

In the first centuries following the Spanish conquest, the Yumbos practically disappeared, due primarily to epidemics such as smallpox, measles and yellow fever (Lippi, 2001). The Tsáchilas of Santo Domingo thus appear to be among the last descendants of the Yumbos and probably of other ethnic groups of the western forests. Traditionally they have spoken *Tsafiki*, a Barbacoan language. The first references to an indigenous group known by early Spanish and mestizo chroniclers as the ‘Colorados’ situates them in a Jesuit *reducción* in 1590 in Angamarca ‘La Vieja’ or ‘La Antigua,’ located about 2,000 m above sea level between what are now the central Ecuadorian parishes of Zumbahua and Pinllopata (Cotopaxi Province), where they lived until well into the 18th century (Navas de Pozo, 1990). During

the colonial period, Maldonado, Haye, and Guérard (1750), Alcedo and Pérez Bustamante (1967) and Hervás (1800) referred to two groups of Colorados, one in Santo Domingo and another in Angamarca. After Jesuit missionaries abandoned the area around Angamarca, there was an indigenous revolt that led to their retreat into the forests, where they mixed with the northern Yumbos to form what are the contemporary Tsáchilas. Since at least the 16th century, they have lived by hunting, fishing, gathering wild fruit and shifting agriculture. They also engaged in extensive commerce with coastal and Andean groups, traveling as far as the Ecuadorian Amazon, most likely to exchange medicinal plants.

Shamanic knowledge, still evident today, was another area of communication and exchange (Salomon, 1997). Although the intensity of these relations fluctuated during the colonial period, it appears that by the beginning of the 18th century they were more limited and by the end of the 19th century – when rubber exploitation began in this area – historical descriptions refer to the Colorados as an isolated ethnicity. This image persisted in ethnographic accounts until the middle of the 20th century, when construction of a highway and colonization drastically transformed social continuity by increasing the *mestizo* population and speeding up acculturation. Up to this point, social organization was based on the extended family in disperse settlements. There was no formal power structure aside from that provided by influential shamans (*pone*) and the *miya* (traditional leaders, later referred to as governors). By the mid-20th century, economic integration resulted in production of bananas, cacao, coffee, corn and achiote, along with cattle, pigs and chickens.

The Tsáchila: social and cultural context

The basic social unit is the family. It is common to find residential spaces in rural areas made up of homes separated from one another by several hundred metres to allow for independence in farming their garden plots. These units support a system of mutual cooperation outside the actual communal structure, and they form the minimal political unit in terms of internal power within the Tsáchila world. Within and between communities, there are economic and social differences. There is a substantial middle class among the Tsáchila who use modern conveniences and send their children to private universities. But at the same time, there are elderly people, abandoned by their families, who live in poverty. There is significant diversity as well in terms of acculturation, with some families and individuals holding more closely to traditional Tsáchila beliefs and practices, and others moving toward *mestizo* and western lifestyles (Ventura i Oller, 2000).

Many Tsáchila, including the shamans, accept that some illnesses have natural causes, and an extensive knowledge of medicinal plants is called upon in curing. The current popularity of Tsáchila medicine has led to a proliferation of healers (known as ‘*vegetalistas*’), whose therapies are based in plants, but who have not undergone the lengthy apprenticeship that would give them the spirit-based curative power that only the *pone* possess. As a defensive mechanism against the incursion of non-Tsáchila healers, they have created an association of officially recognised practitioners of traditional Tsáchila medicine (‘*naturistas vegetalistas*’). But within communities, the *pone* continue to cure at the margins of these associations.

With regard to controlling events beyond the mundane world, the political power traditionally exerted by the shamans has deteriorated as a means for regulating social life. There exists today a boundary between the social and corporeal order, and in their daily

lives the Tsáchila have incorporated western medicine and assistance from western-trained professionals. Periodic deparasitation, the use of contraceptives, surgeries and reliance on biotechnology for diagnosis are common. The Tsáchila today are confronting an epidemiologic transition with the influence of *mestizo* culture, the rise of an indigenous middle class and the rapid growth of the diseases of modernity. Ventura i Oller (2011) maintains that, despite these changes, Tsáchila healers continue to hold true to their cosmology, even as elements of other healing systems are assimilated.

Cultural and economic changes are manifested epidemiologically by increases in cases of anaemia, malnutrition, tuberculosis, diabetes, hypertension, alcoholism, violence and cancer, as discovered by a Hesburgh Hospital study of 800 community members from June 15 to October 1, 2016. Additionally, the Tsáchila must confront new environmental problems posed by 'development' and its attendant consequences, such as contamination of native forests and rivers, which has led to the disappearance of spaces used traditionally for hunting, fishing and healing rituals. Monoculture and the use of agrochemicals have impacted traditional agriculture, which is now practised only by elderly women.

In the *mestizo* world, and for local and national political actors, the Tsáchila culture is valorised as 'the exotic,' useful particularly for tourism purposes (Ventura i Oller, 2000). Such representational practices have a long history, but have become particularly acute with the growth in tourism to indigenous communities (Hutchins & Wilson, 2010). The Tsáchila image is used to attract commerce, sell food and promote certain businesses. Unfortunately, this 'valorisation' has not aided the Tsáchila in gaining political recognition in their own historical territory, nor does it tend to valorise deeper aspects of culture. One thing that has occurred is a growth in 'charlatan' healers, including Tsáchila who – according to Manuel Calazacón, President of the *Asociación de Curanderos Naturalistas Vegetalistas Tsáchila* (Association of Naturalist and Vegetalist Healers) – have appeared in response to the market for medicinal tourism (Andes, 2016).

Both Ecuadorians and foreigners have a double and contradictory image of the Tsáchila. On one hand, they promote complete assimilation into the *mestizo* world, even though few consider them citizens with full rights, with local laws to protect ancestral knowledge, language and culture. On the other hand, the further the Tsáchila move away from the image of 'the savage,' the more they are accused of corrupting their identity. Exoticism is often the only characteristic valued in ethnic minorities. This ambiguity is particularly obvious when one enters the complex world of shamanism, where the majority of patients are mestizos.

The Tsáchila: cosmovision and health

For the Tsáchila, the natural, human and super-human worlds constitute a single complex. But there is also an evangelizing influence, particularly from the Catholic and Protestant churches. Many Tsáchila now identify as Catholics or Evangelicals, but their beliefs remain rooted in aspects of traditional daily life, such as the use of traditional medicine that has a base in the forces of the supernatural world. As with other cultures, the Tsáchila have their own mystical explanations for the events of daily life, influenced by supernatural beings from the worlds below and above and from the realm of the dead. Although rituals are still based in these stories, change has occurred with western influence (Ventura i Oller, 2011).

Illness can originate in both the natural and supernatural worlds. Healers use medicinal plants to treat the former, but only shamans (*pone*) can cure illnesses with origins in the spiritual or supernatural realms. Healing practices and techniques are syncretic and have diversified over the years. For example, body cleansings with eggs increasingly involve medicinal plants that come from other parts of the country. *Ayahwasca* (reference to both the hallucinogenic drink and the vine *Banisteriopsis caapi*, or *nepi* in *Tsafiki*) – now an indispensable element of Tsáchila shamanic healing – is an exchange object from remote times (documented in Navas from the 17th century) (Navas de Pozo, 1990). It is a central feature of indigenous Amazonian healing and is also consumed in the coast by the indigenous Chachi people. Some of the vines planted in Tsáchila territory come from the Amazon and are considered stronger than those grown locally.

The majority of Tsáchila recognise quite well the function of western doctors. But they see a clear incompatibility in some aspects between western and traditional indigenous medicine. Cases of witchcraft, for example, cannot in any form be treated by a doctor, which could worsen the condition. But there is also recognition that certain sicknesses are best treated by doctors. In a sense, the two healing traditions function as parallel systems, rather than as a single, syncretic system. With regard to the skills of traditional healers, we find among the Tsáchila and some rural *mestizo* populations both sceptics and firm believers. But even amongst the latter group, there has been a rapid adoption of some elements of western medicine, such as the idea of preventative medicine. These probably connect with traditional indigenous ideas about causes of sickness, along with concepts related to diet and hygiene (such as therapeutic baths).

At the same time, the practice of analysis prior to any diagnosis – which in Tsáchila tradition occurs via consultation with spirits through ingestion of *ayahwasca* and viewing with the aid of a candle – has been supplemented with the analysis of urine. The shaman uses such analysis to determine whether the sickness is something he or she can treat, or whether it is a matter for doctors. This analysis is carried out with a visual inspection of the entire body of the patient who arrives for a consultation with the shaman because of specific pain. There are also cases of ‘weakness,’ associated with witchcraft, that causes desiccation and general debility in the body, and which are open to new treatments such as vitamins recommended by the shaman. The reality is that western medicine is now incorporated into many therapeutic itineraries, and if the Tsáchila don’t turn to these methods more frequently it is due to lack of access, whether this be economic, geographic, or social.

For Ventura i Oller (2012), inter-shamanic exchanges of knowledge or historical and contemporary alternative healing techniques don’t have to be understood in terms of acculturation, nor as the result of processes of globalization. On the contrary, they are part of a tradition that has been maintained – to the extent possible – by a population faithful to its cosmology without excluding other alternative methods, such as biomedicine. These practices and bodies of knowledge operate as parallel or complementary systems, allowing the Tsáchila to maintain health and cultural continuity. Pedersen and Coloma (1983) documented the evolution of hybrid approaches to healthcare among the highland Kichwa back in 1983, and Finerman (1983) identified some of the tensions that emerge as these processes unfold within networks of historically racialized relations. The most significant material evidence of these multi-ethnic and multicultural exchanges that the Tsáchila display in the symbolic realm is found in the ritual objects present during healing ceremonies, which form part of the healing table (*mesa de curaciones*). The *Tsafiki* term for this table is ‘*misa*,’

which is Spanish for ‘mass,’ and which reflects a syncretic connection with the Catholic altar as well as the terminology used by the Kichwa.

The Tsáchila healers described by Karsten (1988) at the beginning of the 20th century customarily attended to patients in their homes, and when they found them seriously ill, they took them into the forest, where they performed healing ceremonies. The shamans took along their sacred objects in a bag, and displayed them on a small table. It seems these were limited to black stones and the spines of the *chonta* palm. Elderly Tsáchila recall how the shamans (*pones*) healed in small huts equipped in this way. Today, the black stones constitute a fundamental element of the healing table. They are inherited from the Tsáchila teachers, or found during the apprenticeship of new shamans. These are dark and smooth river stones. They are moistened with alcohol, producing a shiny – almost reflective – surface. The *chonta* palm spines have been replaced with other sharp objects such as knives or arrows from the Amazon. To these are added shells from the coast, anthropomorphic figurines from the pre-Columbian period, as well as Christian iconography (including prayer books). The healing tables might also include a *tsantsa* from the Amazon (head shrunk by the Shuar), a skull, or New Age items such as crystals or pyramids often used by Peruvian shamans.

The rapid growth of the city of Santo Domingo, the inevitable cultural mixing and the arrival of global-scale communication systems, has radically changed life in Tsáchila communities. Few youths speak the *Tsafiki* language, and acculturation has provoked a generational rupture. For the elderly, these youths are infants in reference to the white world, while the younger generation sees Tsáchila elderly as outside time. As the young find work outside Tsáchila territory they are exposed to new customs, new forms of education and global means of communication, such as television, cellular phones and the Internet.

Three case studies

A selection of case studies reveals how various realms of healing are entered, understood and negotiated. These cases are based on ‘after-the-fact’ reflections by hospital personnel who treated the Tsáchila patients involved. The cases reflect the complexity of real interculturality, which can be complicated and unpredictable, versus ideal interculturality, which is based on a systems approach that has an essentialized view of indigenous practices.

Case #1

S.A. is a 78-year-old male and – as a *pone* – is a recognized leader in his Tsáchila community. He was the last to be chosen for this by his community as part of an ancestral tradition of identifying a ‘gifted one’ to be healer and was instructed from infancy by another *pone* as an initiation rite. As a *pone*, he adheres more closely to traditional healing, accepting only some aspects of western medicine. Despite his knowledge of ancestral medicine, S.A. has not been able to recover from a pain in the chest and a feeling of fatigue that has developed over a long period. He’s aware that he has high blood pressure, as doctors from the Ministry of Public Health had prescribed medicine for this condition. Nevertheless, he doesn’t take the medicine regularly because he fears his body will become dependent on it. Rather, he takes it when the chest pain returns and stops when it ends. If the pain becomes unbearable he visits doctors in a ministry facility or private practice to get medical attention.

According to S.A., ‘...it’s cholesterol that’s affecting my heart, and this is why my chest hurts. I took the treatment the doctor gave me, but many Tsáchila become dependent on medicines. I don’t eat fat or fried foods, but they tell me I have high cholesterol...’ In the taxonomy of Western medicine, S.A. has pulmonary hypertension, a chronic complication of his high blood pressure. The doctor who treated S.A. has known him for nearly 3 years, and although initially it was ‘shocking’ to see how he reacted to medical treatment, over time he’s been able to better handle the practices of the patient.

The frame of reference of the patient generates social representations of the illness that, although distinct from those of the doctor, nevertheless allow him to construct a causal thread that makes sense (see Figure 2). The doctor’s frame of reference responds to a pragmatic logic of action with a purpose, in a logical framework according to western medicine. The doctor’s therapeutic plan, while it meets the standards of western medicine, does not resolve the health issues from the perspective of the patient. When consulting S.A. about combining medical practices, he responded: ‘Things have already changed, it is not as it was before ...; (western) medicine works, but not for everything.’

Case #2

M.C. is a 55-year-old man who has worked for many years in a company. He says his belief system is closer to the *mestizos* than to the Tsáchilas. He has suffered from low back pain for 6 years. Doctors have indicated this is a minor occupational problem that requires physical therapy that he is actively following. For M.C. the health problem originates in what he defines as stress, that is, the things that happen in his life are affecting his body and that is why ‘the body is weakened, the brain is weak.’ He has doubts that traditional medicine will cure his condition. ‘...I have seen that sometimes Tsáchila medicine works, but other times it does not. I do not believe in it that much because people still die. Before I used to go to the ‘*shaman*,’ but I do not believe much in them anymore.’

In recent months M.C. has experienced multiple episodes of ‘despair, as if something were going to happen to me,’ which has been accompanied by a ‘burning sensation of the whole body, as if I had to run away.’ These episodes occur about three times a day and almost

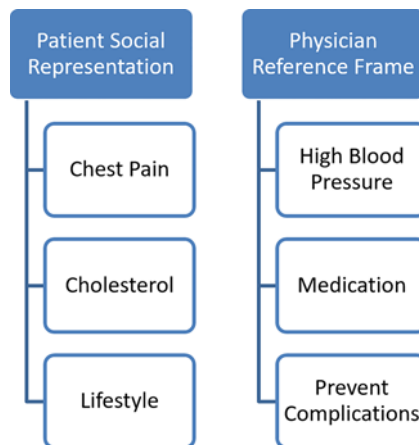


Figure 2. Contrasting social representations between doctor and patient from case one.

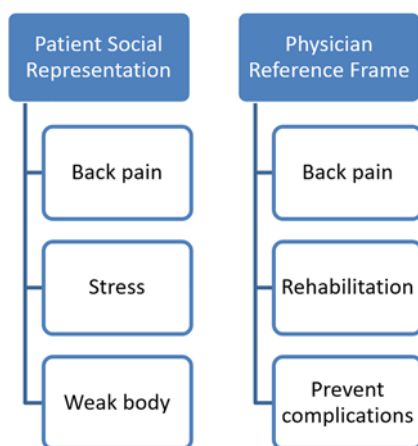


Figure 3. Patient and doctor social representations in case number two.

daily, for which doctors have recommended some lifestyle changes such as more physical activity, as well as having a consultation with a mental health professional. However, for M.C. the discomfort is still part of the ‘stress’ and for that reason he believes that ‘what I need is vitamins to improve the general state of the body and brain.’

This case is relatively different, but it’s also clear that the patient’s frame of reference allows him to identify his social representations with those of the doctors (stress) and build a causal thread that addresses some of his health questions (see [Figure 3](#)). In this case his doubts about traditional medicine have led to the search for another therapeutic option in the western model. Unlike the patient in the first case, this patient appears to be more reflective about choices between the two systems, questioning the effectiveness of ancestral practices.

Case #3

A third patient, J.C., a Tsáchila man, came into Hesburgh Hospital with a fever. He was sent by a commercial farm where he works. A usual workup for fever in the western model of medicine revealed dengue. He was hospitalised for 36 h and asked to leave, even though he was still febrile and ill-appearing. There was no focus initially on the patient’s therapeutic itinerary. There was significant asymmetry between the patient’s understanding and that of the doctor. The hospital doctors were frustrated with the patient’s desire to leave.

Recognizing this disconnect, highlighted in [Figure 4](#), doctors subsequently questioned the patient about his perception of his illness. He said he lives relatively close to a traditional healer. He felt a dangerous, invisible arrow that was intentionally directed towards the healer was deflected and pierced him, the patient. That arrow was responsible for his fever. Doctors acknowledged this, respected that perspective and suggested that upon discharge, he visit the healer to have the arrow removed (complete his therapeutic itinerary), but also complete the medications given to him at the hospital. The patient appreciated that plan and was discharged the next day, satisfied with the care provided (in this case there was no follow-up).

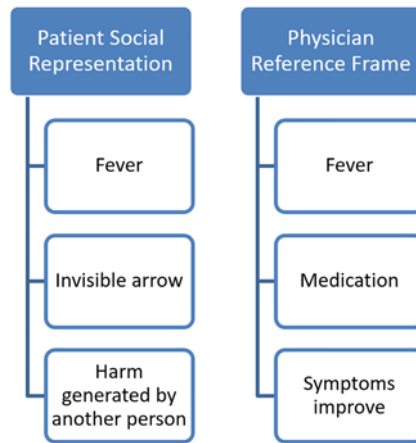


Figure 4. Social representations of patient and doctor in case number three.

Discussion

Kleinman (1988), Nichter (1981) and others long ago ‘culturalized’ conversations about illness and healing by identifying multiple ways that individuals embody and experience health. Mezzich et al. (1999) successfully argued in 1999 for the inclusion of cultural material into DSM-IV, signalling a recognition by mainstream medicine that particular values, belief systems and other realms of meaning should be legitimately considered in the diagnostic process. Farmer (2005), particularly in *Pathologies of Power*, drew attention to the growing field of critical medical anthropology by pointing out that institutions (health, education, political economy) should be seen as key drivers of health inequities. From a global perspective, meaningful conversation about illness and healing across cultural boundaries is confronted by multiple challenges. Knipper argues that in order to avoid stereotyping and perpetuating health inequities, target groups (particularly those deemed ‘ethnic’) must be clearly understood and their cultural values accounted for. As well, the rights of vulnerable groups should be upfront in conversations about medical ethics (Knipper, 2010).

This foundation for intercultural health is not particularly new. Over three decades ago, in an effort to understand what Haraway (1988) called ‘situated knowledges,’ Sánchez Parga (1982) described the ‘path to the cure’ as an organizational framework for how the indigenous patient addresses disease, as seen in the cases described. This ‘path to the cure’ has its own dynamics according to traditions, ancestral conceptions, geography and access to other health services. Indigenous populations pursue this path of healing in a pragmatic, if sometimes spontaneous way. By interacting with healthcare providers in Western medicine, they create relationships that allow the emergence of ‘real interculturality,’ which can have multiple, interwoven parts originating in different cultures. The evolution of an indigenous path to healing can be chaotic and amorphous, contrary to the model of an ‘ideal interculturality’ grounded in essentialized notions of culture. An encounter guided by the ‘ideal’ model is fraught with conflict, because it constitutes a homogenizing practice from a hegemonic vision of modernity and its development projects.

In the three cases, the itinerary – or path – to the patient’s cure in response to his ambiguity towards traditional medicine, has led him along different routes. To accurately describe this endless quest requires some artifice, as shown in Figure 5. Sickness and well-being do

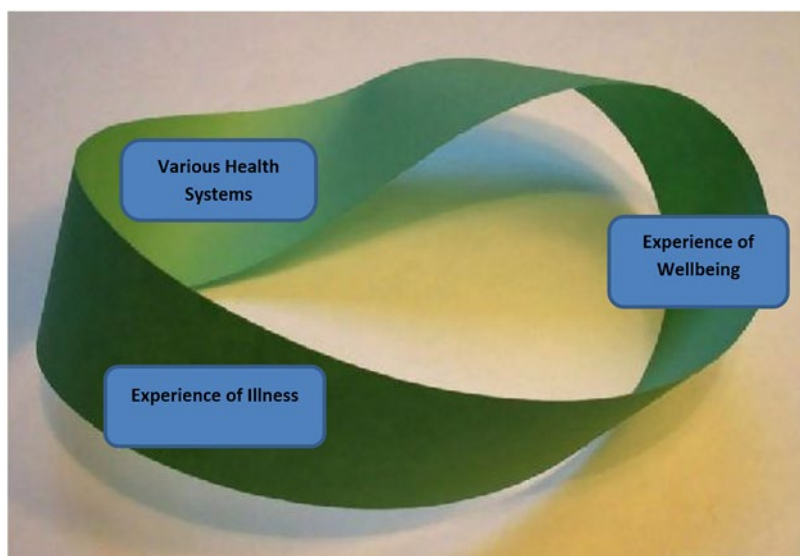


Figure 5. Concept of 'path to the cure' based on a real intercultural model.

not intersect at a specific point, but rather exist as experiences on the surface of the very same path. Along this path, which is like a Möbius strip, the health systems with which the 'patient-traveller' interacts in various ways will be encountered.

Appreciating the tension between real and ideal interculturality as a social phenomenon and political project requires historical context. The making of the Ecuadorian mestizo has long been associated with the nation-building project of *mestizaje*, described by Whitten and Whitten (2011) as 'the blending and 'whitening' of phenotype and culture.' This 'blending' has often come at the expense of indigenous and Afro-Ecuadorian culture, history and language. Quiroga (1999) says this discourse was absorbed into the healthcare system in Ecuador, as white-*mestizo* values and practices became the standard by which modern, clean and healthy indigenous people would be formed. While the pushback against *mestizaje* led to recognition – and perhaps a grudging acceptance – of the cultural plurality of Ecuador, this also tended to fix various non-white groups in time, place and ethnicity by essentializing their identities. Although 'interculturality' was not an explicit part of the language of indigenous uprisings in Ecuador in the 1990s, Whitten and Whitten (2011) says these events opened important conversations about intercultural understanding.

After two decades of heightened activism and protest aimed at broadening rights and promoting inclusion, indigenous groups in 2008 saw a new constitution that embraced these goals. A guiding philosophy for this document was *sumak kawsay*, a Kichwa concept that can be translated as 'good life' or 'living well.' This was touted as a significant departure from neoliberal ideas of 'development,' in that 'good' and 'well' refer not to individual material gain, but to a collective, socially inclusive and ecologically sustainable path forward for a nation with a long history of inequity. Associated with the ideals outlined in the constitution were various objectives to promote 'interculturality.' As physician Hermida (2011) noted in his reflections on *sumak kawsay* in the constitution, this new paradigm included a model for healthcare built around interculturality, discussed specifically in Article 32.

The Ecuadorian model for intercultural health is outlined in some detail on the Ministry of Public Health webpage for the National Office of Interculturality, Rights, and Social Participation in Health, whose mission is to ‘Define and assure the implementation of intercultural health politics, plans, programmes and other tools that guarantee the articulation and complementarity of knowledge, wisdom, ancestral practices and health alternatives in various levels of management and comprehensive care, promoting and facilitating social participation and the exercise of rights’ (Health, 2016).

Strategies for intercultural health are not unique to Ecuador. Experiences from elsewhere in Latin America reveal both the need for more inclusive healthcare systems, and the challenges of putting this inclusivity into practice within structures built largely upon Western models. In publications by groups that have worked in intercultural health since 2004 with the Mapuche people of Chile, the most frequent criticisms that confront national health models are:

- lack of consideration of the multi-dimensional aspects involved in the illness experience
- markedly ethnocentric relationships between doctor and patient, as evidenced by the use of a technical language that is distant from the everyday language of patients
- primacy of cultural homogeneity and the corresponding lack of recognition of cultural differences (Lincoln, Liang, and Mackey, 2015).

Putting intercultural objectives into the constitution and putting them into practice are significantly distinct tasks. In general, Ecuadorian medical personnel don’t understand the syndromes of popular nosology that aid indigenous patients in describing their pains, nor their ideas about the supernatural origins of their ailments, nor the concepts they consider appropriate for treatment. The majority of health practitioners are not trained to practise intercultural medicine neither in ideal nor real terms. The aforementioned cases illustrate the potential disconnect between physician and patient in understanding the complexity of illness and healing. The minimal competencies that doctors need to practise intercultural health are not delivered by medical faculties. In an examination of medical education in Ecuador, Joffre et al. (2013) point to several factors that undergird these shortcomings: 1) the standard medical degree is based on 6 or 7 years of undergraduate study focusing on life sciences education, to the exclusion of the humanities and social sciences (which can contribute to increased cultural competency) and 2) access to higher education is limited by socioeconomic structures that disfavour those from marginalised economic and cultural groups.

Both of these factors potentially reinforce a social system in which ‘difference’ is disparaged and discouraged. These tendencies – to subvert the knowledge and belief systems of the politically and socially marginalised – relate to larger debates about ‘ontological violence.’ The historical denial of indigenous claims to place and identity (or the exotification of such) feed directly into epistemological politics rooted in the colonial era.

Meaningful interculturality would be particularly challenging for health professionals born of an economic and social class that has tended to equate poor hygiene and illness with indigenous and Afro-Ecuadorian groups (Colloredo-Mansfeld, 1998). As Napier suggests in *The Age of Immunology*, survival in the modernist era requires identification and elimination of the non-self, or the potential ‘contaminant.’ With regard to human health, this means developing a powerful immune system. But when the metaphor is translated to

the social body, the objective is to protect against 'the other,' and anything that might compromise the integrity of the self is considered a threat (Napier, 2003). For health professionals enculturated and educated in a predominantly western environment, particularly one with historical racial disparities, interculturality would present both a physical and social risk.

The challenges of cultivating a genuinely intercultural perspective apply to the research process as well, particularly when this also involves interdisciplinary efforts. Researchers on the project outlined in these pages came from social and health sciences. Among physicians who contributed to the project, there was a bias of 'positivism' in the first draft of the article. This bias led to the conceptualization of 'problems' as clear, observable objects. In the discussion of revisions, the introduction of a qualitative method, such as participant observation, led to a more nuanced consideration of issues at the interface of western and traditional healing. From the perspective of the social scientist, the position of the physician/researcher is often poorly understood. In this case, the world of the 'target' culture (Tsáchila) is explored much more thoroughly than that of Western health science, which has its own 'otherness.'

The response of the Ecuadorian government to a healthcare system that evolved within the above-mentioned historical context, and which was ultimately authoritarian, domineering and indifferent to cultural diversity, was the 'ideal interculturality' model we've described. But this model presents various limitations, one being that it prioritises the diagnostic process of the official health system. For example, conversations about parasitosis or the use of family planning methods are guided by the dominant discourse, highly ideologized, which allows for only partial feedback from the patients and which creates a new asymmetrical context. This means that the official health system, when it takes on the concept of interculturality, is instrumentally biased towards its goals and objectives of coverage, denying the level that involves human relations and quotidian affairs.

Opposite the ideal-type model of intercultural health outlined above is an operative type of interculturality recognised when one assumes the position of the patients. This is what we are referring to as 'real interculturality.' When the Tsáchila patient comes into the western hospital, he or she is an active agent within the two health systems. Each individual distinguishes what is pertinent from each system and makes decisions about treatment, as reflected in the cases discussed above. This is different than the passive role often depicted in intercultural models proposed by hegemonic health systems. It is the patient, rather than the systems, who defines how to use the two systems and build their own framework. Real interculturality corresponds to the quality of each system with regard to how it establishes relations with the patient, rather than to the quality of the relation between health systems. To aspire to an interculturality of this type, nevertheless, implies a series of requirements that each local system and health unit needs to take charge of, among them:

- At the institutional level, conscious recognition of the primacy of the patient in the determination of their therapeutic itinerary is required. This necessitates an approach respectful of alternative 'paths to the cure.' This should acknowledge the patient's own medical system, and support the patient in his or her search for meaning in relation to healing and sickness. This does not imply in any way that the official health functionary should employ diagnostic categories or therapeutic procedures of other systems, but only that they are recognised and affirmed.

- At the medical personnel level, development of guidelines and strategies are required for adequate recognition of the therapeutic itinerary of the patient, whose knowledge system and decision-making processes may be quite distinct from the doctor or nurse.
- At the level of the patients, recognition via sociocultural strategies associated with the characteristics of each known therapeutic itinerary and the definition of protocols of relevant attention is required.
- At the level of systematization (sociocultural epidemiology), there should be recognition of the existence of complementary systems, and an openness to indicators of well-being based on the frame of reference of each patient. Breilh and Granda (1989) argue for an approach that is 'phenomenological,' factoring particular social, political and economic realities into the study of disease production and distribution. Epidemiology of this nature should produce a more complete health profile that accounts for Tsáchila realities within the historical structures that continue to affect their lives.

From this perspective, one understands real interculturality as that quality of health systems that permits, promotes and/or strengthens the act of complementarity that the patient carries out in a self-determined form, through his or her own path to the cure. This path-finding quest can have spiritual and environmental dimensions and be influenced by institutional and social relations.

Conclusion

In the real world, it is the health system that ends up being utilised independently by the patient who decides for what and when something ends up being useful. A scenario like this contradicts the vision of the health system that looks for complementarity with other medical systems from their own point of reference. To look at interculturality as a symmetrical relation between subjects of different sociocultural groups, without considering the concomitant sociological and historical factors that demonstrate that this relationship has always been between groups with different gradients of power and influence, ends up being uncritically positivist and ideological. The differences in power and exclusion by the dominant culture should be made explicit in intercultural health. Symmetrical relations are possible only in a process that empowers those who don't have power.

This pattern can fluctuate in a continuum from the abusive relations of contact that were completely asymmetrical to relations of contact characterised by mutual acceptance, valorisation and strengthening. From this perspective, interculturality does not have meaning in itself; rather it emerges from an ethical and moral reflection on the interaction between patient and doctor. In this perspective, there aren't all-or-nothing situations. Additionally, using this focus helps identify relations that, depending on the contexts, can put in an asymmetrical position an actor who in one moment is given power, and in another situation, that position of power is inverted. This focus on real interculturality, now being more fully embraced at Hesburgh Hospital, recognises the Tsáchila patient as the ultimate decision maker who determines when, and how, the health system becomes relevant.

Ethical approval

Information and data for this article were based on existing, non-identifiable data, and thus exempt from IRB review.

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