The relation between biomedicine and local knowledge in primary health care:
Experiences and strategies of the Jambi Huasi health center, in Ecuador

THESIS FOR THE AMSTERDAM MASTER’S IN MEDICAL ANTHROPOLOGY

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SUMMARY / ABSTRACT

This research analyse the relation between biomedicine and local knowledge (which is so-called traditional indigenous medicine in this research) in primary health, based on the experiences and strategies of the Jambi Huasi health center, located in the Otavalo city, in the Imbabura province, Ecuador. The fieldwork took place from May 26th to July 6th of 2008.

The problem revealed by this research is that due to cultural and historical reasons, some indigenous people have not received health care in hospitals, clinics and more units of the formal health system (which is based primarily on biomedicine). In order to provide health care especially to those people, the Indigenous and Peasant Federation of Imbabura (FICI, in Spanish) created Jambi Huasi, more than 24 years ago.

During the fieldwork, it was possible to realize that there are clear differences of opinion regarding the way in which the biomedicine and traditional indigenous medicine are related. Some interviewed people see collaboration; others, a process of subordination or incorporation of traditional indigenous medicine into a hegemonic biomedical system.

The process of “Reference and counter-reference” is one of the practices that the staff of Jambi Huasi has promoted, in order to consolidate the relationship of dialogue, mutual respect and appreciation between biomedical professionals and representatives of traditional indigenous medicine. In practice, this process has been more efficient in the implementation of vertical childbirths.

The Critical Medical Anthropology was selected to support the data analysis, because this approach understands health issues in the context of encompassing political and economic forces that pattern human relationships, shape social behaviours, condition collective experiences, re-order local ecologies and situate cultural meanings; including forces of institutional, national and global scale.

At the beginning of the fieldwork, one of the main research questions was to analyse how biomedicine and local knowledge are deployed in primary health care provided by the Jambi Huasi health center. But, in the light of the data analysis (from the fieldwork and the reviewed literature), I thought it would be necessary to reformulate the main research question, as follows: How does the concept of “intercultural health” allow understanding the way in which different knowledge/practices of biomedicine and traditional indigenous medicine are related in the Jambi Huasi health center? Based on the analysis that could generate the answer to this question, another question would be: Has the relation between biomedicine and traditional indigenous medicine become hybridized in the practice of health care provided by the Jambi Huasi health center?
Motivation

One of the reasons that encouraged me to choose this research topic was the experience that my sister had more than six years ago.

For three years she was suffering from an unclear health problem. While she slept, sometimes a rare fact happened: she had convulsions and she ended up injuring her face, especially her forehead, with her fingernails. Still sleeping, she suddenly started to cry, she screamed loudly. Seeing such a painful scene, my anguished parents tried to help her. When she awakened, she could not remember her dream and could not believe that her face had been injured by herself.

Three general doctors, two neurologists, five psychologists, one yachak, one healer and three traditional doctors offered to investigate her problem. Each one, from their own practical experience and knowledge, gave different interpretations on the origin of her health problem.

When I learned what was happening to my sister, I proposed to my family to help her with mental health care. At the end, through a psychoanalytic care and after applying a practice of hypnosis, it became apparent that her problem had emerged in her childhood, when she was around eight years old, due to the cries of anger and arrogance that a math teacher gave her, when she was unable to solve an exercise. Despite the time elapsed, she was feeling powerless and also was suffering when somebody tried to offend her with words or with actions that made her feel underestimated. Since she got knew the source of her problem, she has not had problems of convulsions, anger, or nightmares during her dreams.

My parents, relatives and I have learned a lot from this experience. So, I am sure that it is not desirable to teach through punishment or underestimation. I believe it is best to teach through examples and based on emotional intelligence.

During the health care process of my sister, I could also realize the importance of beliefs and practices relating to ill health, as a central feature of cultural diversity in Ecuador. For that reason, I thought about the possibility to focusing my analysis on this characteristic, through the research topic that I proposed in this thesis.

I dedicate this thesis, with my deep love, to the sister who allowed me to accompany her in her learning process for solving a problem that was affecting her good health. I also dedicate this work to all those who have accompanied me in my own learning process, and to people who are open to understand the complex context of other countries and cultures, through the analysis of their own experiences, and in a process of “intercultural construction of knowledge”.
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INTRODUCTION

This research reveals that, due to cultural and historical reasons, some indigenous people have avoided to go to hospitals, clinics and more units of the formal health system to look for primary health care. Therefore, in order to meet the demand for this particular indigenous community, the Indigenous and Peasant Federation of Imbabura (FICI, in Spanish) created the *Jambi Huasi* health project, in Otavalo, more than 24 years ago.

The interest in knowing why potential users do not go to the health services accessible to their communities has led to qualitative studies in several countries, especially in areas where indigenous people live.

According to some social science researches, indigenous people often have been marginalized by language, location and cultural beliefs and practices (Ayora 2002; Jacky 2007; PAHO 2002). In those studies, the main problems that indigenous users have identified in health care can be grouped as follows: inconvenient hours of operation and lack of care, lack of professional and supportive staff, mistreatment of patients, lack of direct participation by the community in health efforts, and lack of participation by local agents in the health of the population (PAHO 2002: 38).

The practical impact of this analysis on health system should be analysed in each country.

In order to overcome this problem some countries, such as Ecuador, have signed and ratified a variety of national declarations, agreements, resolutions, and international treaties to benefit the health of indigenous people.

Moreover, governmental, nongovernmental and indigenous organizations have tried to integrate the indigenous medicine with the formal (biomedicine-based) health system.

Such is the case of the *Jambi Huasi* health center, which is in the city of Otavalo, in the Imbabura province, Ecuador. This health center was chosen for developing my fieldwork in Ecuador, because it provides services in primary health care from both biomedicine as well as from indigenous medicine; and because it was founded by an indigenous organization.

In this research I shall explore in how far the conventional distinction between biomedical knowledge/practices and local knowledge/practices remains relevant. On the one hand, interactions between the two practices could have led to a weakening of the distinction. On the other hand, a conflict over patients and status could have led to the distinction remain important.

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1 At the beginning of the fourth chapter, in the description of history, I will explain how the institutional racism and discrimination to indigenous people had limited the access of those people to the formal health services of biomedicine, in Otavalo.

2 *Jambi Huasi* (Kichwa, for "House of Health") is coordinated and administered by the Indigenous and Peasant Federation of Imbabura (FICI, in Spanish). This center provides medical care in Kichwa (the native language) and Spanish, provides both conventional and indigenous medical care, and has indigenous professionals trained in conventional medicine (physicians, nurses, dentists) as well as local medicine practitioners (*yachak*, midwives, traditional diagnosticians). In January 1998 *Jambi Huasi* acquired a legal status under the name "Foundation for Alternative Medicine, *Jambi Huasi*". Since then, it's functioning as a health center in Otavalo.
Statement of the Research Problem

The precarious health and living conditions of indigenous people usually are exacerbated by an epidemiological profile marked by deficiency diseases, chronic degenerative diseases, and health problems linked with urbanization. These shortcomings, according to the Pan American Health Organization (PAHO), justify the urgent need to rethink legal, conceptual, methodological, and operational aspects to afford people equitable access to healthy environments and quality care (PAHO 2002: 1).

Furthermore, the hyper-specialization and complexity of technology based medicine have generated an exclusive vocabulary of techniques and terminologies that are inaccessible for many. This situation has created a great breach in communication between physicians and patients, and to a greater degree the process of intercultural communication with indigenous communities (Erazo 2007: 53-66).

Incorporating indigenous perspectives, medicines, and therapies in primary health care is part of this concern in some town of Andean countries, such as Ecuador.

Although there are links between the different health strategies and resources from biomedicine and the local knowledge, relation between both systems has not always been easy in practice. This problem will be analysed in the context of the Jambi Huasi health center, regarding its primary health care.

So, this research has the following objectives:

1. To analyse how biomedicine and local knowledge (which is so-called traditional indigenous medicine in this research) are deployed in primary health care provided by the Jambi Huasi health center, of Otavalo, in Ecuador.

2. To explore if the distinction between biomedical knowledge/practices and local knowledge/practices, in primary health care, is dissolving or lacking in relevance due to the combing of practices over a long period of time, or if these two ways of knowledge are in conflict in Jambi Huasi.
1. CONTEXT AND METHODOLOGY

1.1. National Context

In Ecuador at least two models of health care coexist: the institutional formal medical model, which is biomedical and supported by the State, and the informal medical models (this research examines the case of the so-called traditional medicine indigenous, of Kichwa Otavalo people).³

The indigenous medical practice, however, was influenced by the Incas and it survived the 14th century Spanish conquest, which undoubtedly transformed it. At the present, this medicine is used by much of the Ecuadorian rural population. People who know and practice this medicine have several names, such as: yachak, jakug, healer, mamahua or “partera” (midwife), “herbalist”, “fregador”.⁴ This study utilizes the word jambigkunà⁵ to refer, in general, to people who provide health services based on traditional indigenous medicine.

In order to benefit the health of indigenous people, some countries have signed and ratified a variety of declarations, agreements and resolutions. The mechanisms for incorporating them into the national legal framework differ, as it does the degree of implementation.

According to the current Political Constitution of Ecuador, approved by the Constituent National Assembly on June 5th, 1998, the development of state policies must be based on a social state of rights: sovereign, unitary, independent, democratic and representative multi-ethnic, participative and of decentralized administration.

The main political and social problems that directly affect health in Ecuador are: the high levels of poverty and its significant increase: 25-30% of the population lives without health care coverage; the ineffectiveness of the National System of Health, due to the lack of leadership and coordination within institutions; the sectors‘ fragmentation; and the insufficient budget with its meagre distribution of resources. (Municipalidad de Cotacachi 2005: 1).

The main reasons limiting the indigenous communities’ access to the health services of the Ministry of Public Health in Ecuador have been geographic, linguistic and economical, as has also been the cultural and racial discrimination.

³ In this research the term "traditional indigenous medicine" is referred, because it is the most used by people interviewed during the fieldwork.
⁴ The definition of these terms can be found on the Glossary, in the Annex 6.1.
⁵ This word is used in the Jambi Huasi health center, in order to refer to: yachak, “partera” (or mamahua), jakug, “herbalist” and “fregador”).
To overcome these problems, more than 10 years ago, through the National Direction of Health for Indigenous People (DNSPI, in Spanish), the Ministry of Public Health of Ecuador initiated an intercultural health program to build networks among indigenous organizations, government health departments at various levels, health care providers and NGOs.

With the purpose of overcoming those problems mentioned above, the current Constitution of Ecuador also included subjects of the multiculturalism and multi-ethnicity of the Ecuadorian State and the collective rights of indigenous and Afro-Ecuadorian people, in relation to their “systems, knowledge and practices of traditional medicine, including the right to the protection of ritual and sacred places, plants, animals, minerals and ecosystems of vital interest, from the viewpoint of this medicine”. (Article 84, paragraph 12) This Constitution further recognizes the contribution that ancestral cultures have provided to the health care of the Ecuadorian nation.

The text of the project for a new Constitution has been approved by the Constituent Assembly of Ecuador on 24th of July, 2008, and it will be subject to popular referendum on September 28th of 2008. About the health subject, the Constituent Assembly adopted 9 articles; among them, it says that the State has the responsibility to strengthen health services and to ensure the ancestral and alternative health practices. The new Constitution confirms that health services may be provided through the state, private, autonomous and community agencies; and that in places both (the alternative ancestral medicines and the complementary medicines) should be provided.

This new Constitution also declares Spanish as the “official” language of Ecuador, while Spanish, Kichwa and Shuar⁶ are official languages of intercultural relation. Other ancestral languages are for official use of the indigenous nationalities in the zones where they inhabit and within the terms determined by the law⁷.

An innovative aspect of the new Ecuadorian Constitution is the recognition that rights of indigenous people are not only as an issue reflected in the Declaration of Plural-nationality of Ecuador, but as recognition of interculturalism.

“Etymologically, this implies that if the practice of education and health is not intercultural, as a basic right of interculturalism, it will be impossible to reach the legal recognition, the political and social status of a country with diversity of nationalities. Although, so far, many nationalities are linked not only in terms of tolerance but of synergy”, according to Elizabeth Núñez, Communication Director of the Ministry of Public Health of Ecuador, who believes that interculturalism is a fundamental requirement for the declaration of a Plural-nationality State.

⁶ Shuar is an indigenous language spoken in the Ecuadorian and Peruvian Amazon.
About the health status of indigenous people\(^7\), according to a report written by the Jambi Huasi health center’s leaders, four years ago, Ecuadorian indigenous populations have developed expertise in a variety of areas, such as traditional medicine. “However, this knowledge has not been recognized as such and, in order to devalue it, some people have described it just as ‘skills’. Moreover, racial discrimination, social and economic abuse, and exploitation have influenced the critical situation of the indigenous population’s life”. (Conejo et al. 2004: 7)

A situation that is reflected in the health status of indigenous people,\(^8\) which has not improved significantly despite the fact that the Ministry of Public Health of Ecuador has promoted several efforts and has expanded the coverage of health services.

Although many indigenous populations have developed and have relied on the utility of the health system of their indigenous ancestors, this fact has not been enough to solve the health problems caused by the insecurity, malnutrition, environmental pollution, and their socio-economic status. According to the director of Jambi Huasi, Myriam Conejo, statistical data have usually been homogeneous and they have hidden some problems of indigenous people, “which still persist”. (Conejo et al. 2004: 8)

1.2. Provincial Context

The Imbabura province is home of Kichwa indigenous people, “mestizos”\(^9\) and Afro-Ecuadorians. It has a population of around 329,755 inhabitants (48.2% “mestizo” people; 40.1%, indigenous people, and 11.7%, black people), and a rural population of 51.8%.

In the year 2000, the incidence of poverty was of 77.8%, according to the Municipality of Cotacachi (2005). The rate of illiteracy in 1990 was 16.0%; for the year 2000, the index of the educational action was of 42%. The unsatisfied basic needs in 1994 were located at 40.3%; and in 2000 this index was 57.5%. The global rate of fertility for 1000 women was 3.9

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\(^7\) Sources in Ecuador estimate that the indigenous population of the country is among the 1 million and 4 million people; therefore, indigenous communities could represent 10% or maybe 40% of the population. This huge difference in the data is related to the concept of being an indigenous person (pure indigenous, indigenous “mestizo”, indigenous peasant). However, this problem is more serious than just a lack of a trustful census. The size of the indigenous population within the national sphere shapes the political and social structure of the country.

\(^8\) Indigenous people in Ecuador are usually located in communities which are geographically far from cities or urban areas, most of them do not have vial access. For these reasons, it is difficult for some indigenous people to attend to health care in cases of emergency. In addition, many men have migrated for working and many adult women speak only Kichwa, so this, many of those women do not usually leave their communities. In the case of the indigenous women who actually go to the city, they must find someone who takes care of their children, the house and animals, and also they must be prepared to confront situations of abuse, racial discrimination, difficulties with a new language, and the fear of not being able to return the same day to their house. For these reasons, many indigenous people prefer to receive health care in their own communities.

\(^9\) “Mestizo” is a person who descends from Spanish and indigenous people.
(for the period 1994-1999); the annual birth rate in 1998 was of 29.4 for a thousand inhabitants. Life expectancy at birth during the period from 1995 to 2000 was 66.4 years (Municipality of Cotacachi 2005: 2).

In the next section, I turn to a brief description of the localized contexts of Otavalo, an urban setting that is experiencing both locally produced social upheaval as well as national level economic crisis.

1.3. Setting of study: Otavalo

At an altitude of 2550 meters, in the Andes of Ecuador, lays the ancient city of Otavalo, whose population is around 31,000 inhabitants. Its area is of 507 square kilometres, the equivalent to one eighth of the province of Imbabura. The Otavalo canton is composed by the city of the same name and 11 parishes: two urban and nine rural.

The town of Otavalo is located 110 kilometres north of the capital of Ecuador, Quito, and 25 kilometres south of the provincial capital, Ibarra. Although here the official language is Spanish, many people also speak Runa Shimi or Kichwa. Most people who are living in the canton of Otavalo are of origin: Kichwa Otavalo, Kichwa Kayambi, and “mestizo” people.

“It is a society where, despite the diversity of population, there is unity, based on mutual respect and common objectives, yet fundamentally being responsible citizens, aware of their rights, but also of their obligations”. This is the opinion of the Otavalo’s mayor, Mario Conejo, an indigenous Kichwa Otavalo who has been mayor of the canton for eight years.

Due to its location, Otavalo is the most important tourist area in the northern of Ecuador (O’Neill et. al. 2006: 34). This is the major production centre and market of traditional textiles in

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10 This language is result of a fusion between the Quechua language brought to the region by the Incas from Peru and indigenous pre-Kichwa languages

11 His sister, the physician Myriam Conejo, is the director of the Jambi Huasi health center, the place where the study case of this research was developed.
Ecuador. It is the site of an ethnic economy based on the manufacturing and brokering of its indigenous and other group's ethnic clothing and handicrafts, which are sold abroad, on several continents, by their own Kichwa-speaking merchants. A more recent cultural commodity offered by this region is the folkloric Andean music, which is played in several countries (Kyle 2002: 29-51).

The Otavalo people are one of the most recognizable indigenous ethnic groups in the Americas, due to their historical and socio-cultural strength, which has permitted them to maintain their customs and traditions over time. Their musical talents, artisan skills and traditional style of hair and dress enjoy world renown, as well as its famous handicrafts market.

An interesting component in Otavalo is the Indigenous Midwives Association, which was formed in 2002 to monitor the certification of traditional midwives in the region. There are more than 64 midwives registered in the Association, however there are many more unregistered midwives in the canton of Otavalo, which is a problem, according to the Provincial Health Direction of Imbabura, because several cases of Maternal Child Deaths have been attended by non-trained midwives.

Although this Association is independent of the Jambi Huasi center and the FICI, it coordinates its activities with Jambi Huasi through periodical meetings. The Municipal Health Direction supports these meetings by providing resources for training, as well as some equipment.

Another component is the Yachak Association of Iluman, a small community near Otavalo. In 2005, this Association had in its register 47 members, including some from surrounding localities (O'Neill et. al. 2006: 34). Some of them have worked in the Jambi Huasi health center.

The Indigenous and Peasant Federation of Imbabura (INRUJTA, in Kichwa, and FICI, in Spanish), is the provincial organization of indigenous people. This is located in the city of Otavalo. Changes in lifestyle of the indigenous Kichwa Otavalo population, as a result of emigration, as well as the problems of indigenous people for accessing to health care, have influenced to the FICI in seeking strategies that strengthen the identity of indigenous peoples; therefore, redemption and vindication of traditional indigenous medicine has been one of its crucial goals. To support this objective, in 1983 the FICI created the Health Project Jambi Huasi, which in 1998 acquired its legal status under the name “Foundation for Alternative Medicine, Jambi Huasi”.
1.3.1. Case Study: Jambi Huasi health center

“We started the project Jambi Huasi with the idea of breaking certain prejudices, to regain awareness and knowledge of traditional indigenous medicine, so that, it can contribute to Western medicine (Biomedicine). Through Jambi Huasi, we wanted to prove that we are not ignorant people” (Myriam Conejo, director of the Jambi Huasi health center).

A cosy old house in a central area of Otavalo is the place in which the Jambi Huasi health center currently operates. This center was founded by the Indigenous and Peasants Federation of Imbabura (FICI, in Spanish) in 1983, and since 1994 it provides health services based both on biomedicine as well as on traditional indigenous medicine.

Services from biomedical health care include physicians (two sharing a full-time position), a dentist that is available four days per week, and a laboratory that provides medical tests like Pap smears and HIV/AIDS tests. Another alternative includes services of a yachak (spiritual healer available one day per week), a “fregador” (herbalist/massager on a full-time basis) and also, on a full-time basis, a mamahua (partera, in Spanish; midwife, in English).

According to the authorities of Jambi Huasi, “health can only be understood in its social and cultural context; based on the principle of solidarity, reciprocity, integrality, laboratory, and indigenous medicine, including the service of a traditional birth attendant”. (Conejo et. al. 2005)

Operating under the assumption that health needs can only be addressed successfully within their own social and cultural context, Jambi Huasi had adopted a rights-based approach of integrated services, in respect to cultural traditions, social solidarity and reciprocity.

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12 Since the end of 1994, the Jambi Huasi's director the physician Myriam Conejo, who is Kichwa indigenous. In 2006, she received an international prize from the UN, through the UNFPA, “for working in favor of native women of the Imbabura province”, in Jambi Huasi. This health center also received the “Cotama Prize”, from the Otavalo Municipality, on October 2004, in recognition for its contribution to the community.

13 The FICI is an indigenous organization supported by 160 communities in the Imbabura province. It also represents the region as part of the Confederation of Indigenous Nationalities of Ecuador (in Spanish: Confederación de Nacionalidades Indígenas del Ecuador, CONAIE).

14 More information about history of the Jambi Huasi health center, in the section 3.1.
According to the foundation statutes of Jambi Huasi, the mission of this center is “to offer quality services, with humanitarian treatment and timely, without racial, social or economic discrimination” (Conejo et. al. 2005: 13). Part of its mission is to respect the worldview of its patients; to provide comprehensive health care; to promote the political commitment of the staff with the community, and to encourage inter-agency coordination with full indigenous participation. With this purpose, the center promotes the coordination of the traditional indigenous medicine and the biomedicine, as well as the recovering and revaluing of the traditional indigenous medicine and the role of its Jambigkunas.\(^{15}\)

**Relationship FICI - Jambi Huasi\(^{16}\)**

The FICI has been the driving force in the creation of Jambi Huasi. In 1974, due to inadequate health conditions of the indigenous population of Imbabura, the FICI raised the need to include among its lines of action the health issue and therefore it supported the creation of the health area Jambi Huasi in 1983. The aim of its foundation was: “to establish a center for alternative medicine linking indigenous medicine and Western medicine (biomedicine), taking into account the worldview of the Imbabura province inhabitants”. (Conejo et al. 2004: 6)

In this way, the foundation of Jambi Huasi was as a response from the indigenous organizations to the lack of attention given to health of indigenous people (Conejo et. al. 2005). “Jambi Huasi is a dream (...). It is as a cultural response”. This was confirmed by the indigenous leader Blanca Chancoso,\(^{17}\) who was member of the administration of FICI when Jambi Huasi was founded.

“During the first phase of Jambi Huasi (from 1983 to 1992), this center had offered its health services completely free to both the urban as well as the rural population. One peculiarity of this period was that the work of Jambi Huasi was linked to organizational activities of the FICI. However,\(^{18}\) difficulties within the FICI and the lack of economic resources of Jambi Huasi influenced the closing of the center to the public on several occasions. The last time the center suspended its services was in 1992.

In 1994, Myriam Conejo and the Jambi Huasi’s team presented their project to the United Nations Population Fund (UNFPA), which gave economic support at the center to develop the project entitled “Integrated Health Care for Indigenous and Peasant Women of Imbabura” in

\(^{15}\) This study utilizes the word Jambigkuna to refer, in general, all who know and who practice traditional indigenous medicine, including Yachak.
\(^{16}\) More information about history of the Jambi Huasi health center, in the section 3.1.
\(^{17}\) This point of view was stated in an institutional video, produced by Jambi Huasi with the support of the UNFPA.
\(^{18}\) The first Jambi Huasi health team was conformed by doctors and Mario Maldonado, Nancy Nunez, the yachak Taita Churo, and Roberto Conejo; at that time, the FICI was managed by indigenous leaders, such as Fausto Jimbo and Blanca Chancoso.
Otavalo. From that date to the 2006, Jambi Huasi focused on a programme of sexual and reproductive health.

To implement this project, leaders of Jambi Huasi proposed to adopt the same characteristics as the original project: to be a health center that combines traditional indigenous medicine and biomedicine in providing care to ten communities surrounding the canton of Otavalo, and to people who come to this health center. Unlike the initial stage and, despite being a non-profit entity, during the second phase (which began in 1994) the Jambi Huasi's authorities decided to charge a minimum fee for the provision of health services. “Our interest has been to work on developing a proposal for the provision of responsive health services, meeting the characteristics of a diverse population and, furthermore, to generate proposals on health policies for indigenous people” (Conejo et al. 2004: 7).

With the creation of Jambi Huasi, another purpose of the FICI, was to support the work of indigenous professionals trained in biomedicine. As Myriam Conejo recalled, even though in the Imbabura province many indigenous biomedical professionals were trained, very few of them worked as doctors and most of them returned to work in craft activities; as employees in the informal, domestic and agriculture sector”. (Conejo et al. 2004: 7)

For people working in this center, health is an intimate aspect of life, and ideas about causes and treatment of illness are often situated in a specific cultural context.

1.4. Methodology

This thesis is the result of a small-scale research that was carried out for six weeks, from May 26th to July 6th of 2008, in the Jambi Huasi health center, Otavalo, Ecuador.

This study adopted an exploratory design. Its aims were to take into account the experiences of biomedicine professionals, of practitioners of traditional indigenous medicine, and of patients of the Jambi Huasi health center, in Otavalo.

In-depth and semi-structured interviews were the main data collection technique in this research. Other techniques were: Observation and collecting documentary material. More detailed information on “Data Collection Tools and Techniques” can be found in Annex 6.3.

The data were gathered mainly in the Jambi Huasi health center, which is located in the city of Otavalo, in the Imbabura province in northern Ecuador.

The interviews and (Participant) Observation were done mainly in the waiting room, consultation room, corridor, and other places within the establishment of Jambi Huasi, as well as elsewhere in the Imbabura province and in institutions located in Quito (such as: Ministry of Public Health and the Andean University Simon Bolivar). So, this research has taken into account
the triangulation of the following research methods: in-depth, semi-structured interviews, observations, and analysis of collected documentary material.

I arrived in Ecuador the 19th of May of 2008. Every week I have sent a report to my supervisor, to reflect with him on the used methods, the found data, and to discuss the problems that might come up during the fieldwork. Through those reports we decided to use the term "relation", instead of the term "harmonisation"; and focus the fieldwork only on experiences and strategies of the Jambi Huasi health center, in Otavalo (and not also in the Jambi Mascari center, in Cotacachi, as initially intended).19

About the sample, my informants were biomedicine professionals, practitioners of traditional indigenous medicine, and patients of the Jambi Huasi health center. The exact number of interviewees was based on the information offered by the first six interviewees.

During my fieldwork, I was able to interview 8 persons of the staff of Jambi Huasi; 3 patients of this health center, and 9 persons representing various institutions (3 are academic researchers, 2 are coordinators at the Ministry of Public Health of Ecuador; 2 represent the Provincial Health Direction of Imbabura; 1 is the director of the public Hospital of Otavalo, and 2 representatives of the municipality of Otavalo). In addition, during the two first weeks of fieldwork I could interview two important members of the staff of the Jambi Mascari center, and two representatives of the Cantonal Program on Intercultural Health of Cotacachi (one of them was the former director of the public Hospital of Cotacachi, and the other is the coordinator of the Intersectoral Health Committee in this canton).20

In total, I was able to interview 25 persons. Structured interviews (N= 15) included open-ended questions and, in some cases, led to longer conversations about the personal histories. Total time of observation in Jambi Huasi was approximately 40 hours.

Additionally, I was able to access to reports related to the consultation of patients in Jambi Huasi, during the period 2nd – 27th June of 2008; these data were delivered by biomedical professionals and by traditional indigenous medicine practitioners of this health center. Based on them, it was possible to develop some graphics that illustrate and/or confirm analysis presented in this thesis.21 Regarding to the plan for data collection and analysing, in this research I explored:

(1) How are biomedicine and local knowledge (which is so-called traditional indigenous medicine in this research) deployed in the practice of primary health care, in the Jambi Huasi health center?

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19 The reasons of these changes are detailed in Section 1.3.1., and in the Annex 6.2.
20 After those interviews and observation practices, it was possible to confirm that would it require more than 6 weeks developing a research in the Jambi Mascari center and, especially, that due to circumstances of this centre would not be possible to answer the research questions there. For this reason, since the third week the fieldwork focused only at the Jambi Huasi health center.
21 These graphics are in the section 3.2. of this thesis.
(2) Has the distinction between biomedical knowledge/practices and local knowledge/practices lost its relevance or do these two ways of knowing have conflict with each other in the primary health care provided at Jambi Huasi?

(3) What are the strategies of communication used in primary health care by Jambi Huasi, and how do these affect the relation of biomedicine and local knowledge?

For answering to (1), I explored the place of biomedicine and traditional indigenous medicine in the practice of primary health care, from the perspective of recipients of care (patients) and from the perspective of the providers, and the communications between them both.

For answering to (2) I tried to observe during my fieldwork: whether the distinction between biomedicine and traditional indigenous medicine has become less clear over time, and how the two forms of knowledge and practice influence each other.

The answer to (3) was based mainly on interviews with patients, with providers, and on the observation of the communication processes. Special emphasis was placed on the influence of strategies of communication between biomedicine professionals, local medicine practitioners and patients of Jambi Huasi, regarding primary health care.

About ethical considerations, the credibility and the honesty of my intentions are important to me. For this reason I introduced myself during the fieldwork as who I am: a student of the Amsterdam Master's in Medical Anthropology (AMMA) at the University of Amsterdam, in the Netherlands, who was developing a fieldwork to support the development of a thesis.

The research objectives and goals of the fieldwork were explained clearly to all informants before interviewing them. The permission to observe in the consulting rooms of Jambi Huasi was granted by the director of this health center, Myriam Conejo. In each case, permission to record interviews or consultations was requested.

To protect the well-being of the informants, I asked them if they preferred to maintain their name in anonymity, but only three of the 25 people interviewed wanted to use a fictitious name for the thesis.

Furthermore, throughout the fieldwork, I tried to respect and/or observe local cultural values, beliefs and norms. So, I have fulfilled the following requirements: Informed Consent, protection of the privacy of informants, confidentiality, plan for data analysis, and pretest.

Due to the short time dedicated to the fieldwork, the pretest for supporting the research proposal consisted on conducting interviews with three couples of Kichwa Otavalo people who are living in Amsterdam. This allowed me to test the topic guide and to determine: the time it takes to conduct an interview, if the questions were clear, and if the questions were relevant. The interview guide was modified based on the results of the pretest.
2. THEORETICAL APPROACH

In order to understand the cultural representations of health and illness in biomedicine and traditional indigenous medicine, the analysis about "medical pluralism" would be useful. The degree of pluralism seen in Andean health systems\(^{22}\) is in large part due to the negotiation of illness by local agents. This greater recognition of agency among participants in health systems is a key theme reflected in more recent medical anthropology in the Andes and the role of gender, class, and power in these negotiations is well recognized. Individuals are enmeshed in webs of social relations that influence their experience and options, and they act from multiple motives -or motives that can change over time. In so doing, they construct and reconstruct the pluralistic health systems in which they participate. (Miles & Leatherman 2003: 10)

Medical pluralism flourishes in all class-divided societies and tend to mirror the wider sphere of class and social relationships. It is perhaps more accurate to say that national medical systems in the modern or post-modern world tend to be "plural" rather than "pluralistic", in that biomedicine enjoys a dominant status over heterodox and ethno-medical practices.

"In reality, plural medical systems may be described as 'dominative' in that one medical system generally enjoys a pre-eminent status vis-à-vis other medical systems. The existence of dominative medical systems in complex societies predates capitalism". (Baer 2003: 44)

As Charles Leslie\(^{23}\) observes: “All civilizations with great traditional medical systems have developed a range of practitioners from learned professional physicians to individuals who had limited or no formal training and who practiced a simplified version of the great traditional medicine. Other healers coexisted with these practitioners, their arts falling into special categories such as bone setters, surgeons, midwives, and shamans”. (Leslie 1974: 74)

In the second chapter of this thesis I will try to argue how the medical pluralism in the Andes has been deployed and its influence in the Jambi Huasi health center. Moreover, in this chapter I try to analyse how does the concept of 'intercultural health' allow to understand the way in which different knowledge/practices of biomedicine and traditional indigenous medicine are related in the Jambi Huasi health center; as well as the contrast of views and interpretations on this concept. In addition, the use of the concept of hybridization will be considered in the analysis of this chapter.

\(^{22}\) In the Latin American context, medical pluralism has been well documented and frequently discussed in literature (see, for example, Crandon 1986; Davidson 1983; Finkler 1991; Pederson and Coloma 1983; Young and Garro 1981). Based on this literature, biomedicine, folk medicine (especially home remedies), and traditional medicine (including spiritualist healing) have been shown to exist alongside one another and to be alternately or even concurrently utilized by individuals depending on a wide range of variables and conditions.

\(^{23}\) He is an anthropologist, who has conducted extensive research on South Asian medical systems.
This chapter is divided into three sections: 1) (local) indigenous knowledge, 2) biomedicine and local knowledge, and 3) intercultural health construction.

Libbet Crandon-Malamud raised very interesting questions about medical pluralism in the Andes, some questions that anthropologists have been exploring and trying to answer for decades and that were presented in the book Medical Pluralism in the Andes (Koss-Chioino et al. 2003). For the research topic of this thesis, an interesting contribution could be the following argument by Crandon-Malamud: “Medicine is a critical domain to our sense of selves, infused with enormous power and riddled with different paths that access material and nonmaterial wealth”.

(Crandon-Malamud 1991: 205)

In Otavalo, outcomes or resort of various medical alternatives may reflect reality, but they also could reinforce Libbet's principal conclusion, that a cure is only one of many goals or outcomes of medical choice.

This research also considers the analysis from the Critical Medical Anthropology, because it understands health issues in the context of encompassing political and economic forces that pattern human relationships, shape social behaviours, condition collective experiences, reorder local ecologies and situate cultural meanings, including forces of institutional, national and global scale. So, the emergence of critical medical anthropology reflects both the turn toward political-economic approaches in anthropology in general as well as an effort to engage and extend the political economy of health approach. (Baer & Singer 1996: 21-40).

According to the previous literature review, Critical Medical Anthropology recognizes that patterns of medical pluralism tend to reflect hierarchical relations in the larger society. Patterns of hierarchy may be based upon class, caste, racial, ethnic, religious, and gender distinctions.

Another interesting contribution to this research offers the analysis of the concept “Situated Knowledge”. It is a useful foundational concept, in that it acknowledges differentiated locations, and affirms these locations as starting points for the production of knowledge (Nazarea 1999). By analysing this concept it is possible to recognise that knowledge is subjective and that there are different situations from which knowledge may arise.

In order to analyse the way how biomedical professionals, jambigkunas (indigenous medicine practitioners) and patients understand the relation of biomedicine and traditional indigenous

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24 While ecology and adaptation dominated earlier perspectives on health, research in the 1980s and 1990s adopted a broader framework that recognizes the role of macro-political and economic factors in structuring local environments, and the importance of social relations in shaping and health. This shift followed developments in Andean ethnography, biological studies, and in critical medical anthropology. “These new perspectives have led Andean medical anthropologists to expand their earlier definitions of environment and adaptation to acknowledge the multifaceted ways that social, economic, and political forces shape the nature of Andean life”. (Miles & Leatherman 2003: 10)
medicine in primary health care at Jambi Huasi, this research also considers the concepts of intercultural health and the category of complex medical system.

Therefore, I will highlight the contribution of medical anthropology from a holistic approach, taking into account the socio-cultural dimensions of health and illness.

*Early anthropological perspectives on Medical Pluralism*

Regardless of their degree of complexity, all medical systems are based upon dyadic core consisting of a healer and a patient. In complex societies, the medical system—the ensemble of medical beliefs, practices, and social structures—consists of the totality of medical subsystems that coexist in a cooperative or competitive relationship with each other.

Many of the early researches on medical pluralism focused on the creation of typologies that recognize the existence of this phenomenon in complex societies.

In this section four classificatory schemes will be presented. Those schemes have been devised by Frederick Dunn, Charles Leslie, American medical system, and Complex medical system (proposed by a Research Group of the University of the State of Rio de Janeiro, Brazil).

1. Frederick Dunn

Based upon their geographic and cultural settings, the anthropologist Frederick Dunn delineated three types of medical systems: (1) local medical systems; (2) regional medical systems, and (3) the cosmopolitan medical system. (Dunn 1976: 133-58)

With the term “local medical systems” he refers to "folk" or "indigenous" medical systems of small-scale foraging, horticultural or pastoral societies, or peasant communities in state societies.

Regional medical systems are system distributed over a relatively large area. Examples of regional medical systems include Ayurvedic medicine and Unani medicine in South Asia, and traditional Chinese medicine.

Cosmopolitan medicine refers to the global medical system or what commonly has been called “scientific medicine”, “modern medicine”, or “Western medicine”. (Baer 2003: 43)

Complex societies generally contain all three of these medical systems. India, for example, has numerous local medical systems associated with its many ethnic groups; Ecuador as well. This variety of medical systems could also been found in the city of Otavalo. Biomedicine and traditional indigenous medicine are the best well-known.

2. Charles Leslie

The anthropologist Charles Leslie has delineated five levels in the Indian dominative medical system: (1) biomedicine, which relies upon physicians with MD and PhD degrees from prestigious institutions; (2) "indigenous medical systems", which have within their ranks practitioners who have obtained degrees from Ayurvedic, Unani, and Siddha medical colleges; (3) homeopathy, whose physicians have completed correspondence courses; (4) religious scholars or
learned priests with unusual healing abilities; and (5) local folk healers, bone-setters, and midwives.

Succinctly, Leslie summarized the contradictory role that traditional medical systems play in South Asia and elsewhere, with the following words: "[Traditional] physicians... are sometimes painfully aware that cosmopolitan medicine [or biomedicine] dominates the Indian medical system, yet a substantial market exists for commercial Ayurvedic products and for consultations with practitioners. The structural reasons that medical pluralism is a prominent feature of health care throughout the world are that biomedicine, like Ayurveda and every other therapeutic system, fails to help many patients". (Leslie 1992: 2)

This point of view could also be taken into account to determine the presence of several medical systems in Ecuador, especially in places with an indigenous population, like in Otavalo.

3. American medical system

The American dominative medical system consists of several levels that tend to reflect class, racial/ethnic, and gender relations in the larger society.

In rank order of prestige, these include (1) biomedicine; (2) osteopathic medicine as a parallel medical system focusing on primary care; (3) professionalized heterodox medical systems (namely, chiropractic, naturopathy, and acupuncture); (4) partially professionalized or lay heterodox medical systems (e.g. homeopathy, herbalism, reflexology, massage therapy, and Rolfing); (5) Anglo-American religious healing systems (e.g. Spiritualism, Seventh Day Adventism, Christian Science, Unity, and Pentecostalism); and (6) folk medical systems (e.g. Southern medical systems such as “curanderismo”, “espiritismo”, “santeria”, and Native American healing systems).

As a result of the financial backing (of initially corporate-sponsored foundations, and later the federal government) for its research activities and educational institutions, biomedicine got scientific superiority and clearly established hegemony over alternative medical systems.

4. Complex medical systems

The Research Group of the University of the State of Rio de Janeiro, Brazil, is a strong group of research in Latin America, which is led by Madel T. Luz.\textsuperscript{25} Analysing the relationship of several medical systems, she raises fundamental questions as: Are we talking about knowledges, skills or science; therapies or practices?

\textsuperscript{25} Dr Madel T. Luz is Professor of the Institute of Social Medicine at the University of the State of Rio de Janeiro, Brazil.
Inspired by these questions, Madel T. Luz analyses the category of “medical rationality”, which she uses to identify the so-called Complex Medical Systems.

According to Luz, a medical rationality must have at least five key dimensions: 1) morphology, 2) vital dynamics; 3) medical doctrine; 4) diagnostic system, and 5) system of therapeutic intervention (Luz 1996: 5). In this case, a medical rationality could be valued as a Complex Medical System.

Based on these characteristics and on the category of medical rationality, Luz identifies four complex medical systems: 1) The contemporary western medicine, or biomedicine; 2) the homeopathic medicine; 3) the china traditional medicine; and 4) the Ayurveda medicine. (Luz 1996: 3)

From the cultural perspective, these four complex medical systems are characterized by medical rationalities coming from complex and highly differentiated societies, according to Luz.

The Ecuadorian researcher Raul Mideros and other researchers of the Andean University Simon Bolivar are discussing if the Andean Amazon medicine has all the necessary conditions to be considered a complex medical system. In this context, different techniques of diagnosis and treatment, based on traditional indigenous medicine and used in Jambi Huasi, could be part of the Andean Amazon medicine.

In order to explain why it is difficult to make a comparison of knowledge/practices based on biomedicine and on traditional indigenous medicine, such as those services that Jambi Huasi provides, Raul Mideros poses a parallel between the medical system of the Andean region and the Eastern medical system.

“It is quite clear that health issues in Andean communities are similar to health issues of East medicine, because both don’t work on the basis of mental models, as Europeans usually do. With these models, Europeans seek to build the objective situation or the final situation, and then subordinating their action to that situation (...). But the Andean medicine and the Eastern medicine do not work with mental models. For example, a yachak or mamahua (midwife), although they have an experience that could give them guidance in their work, do not feel

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26 “Medical Rationality” is one of the main categories used by Madel T. Luz in her researches. This concept is doubly inspired on the work of Max Weber: from a theoretical point of view, or notional (that is, by its content in significant terms), and from a methodological point of view, i.e., of its construction. For more information about characteristics of the term medical rationality, review the theoretical-comparative research conducted by Luz between 1991-1994, as part of her project called “Medical Rationality”, in the Institute of Social Medicine of the University of the State of Rio de Janeiro.

27 Raul Mideros is Doctor of Medicine and Surgery. He studied a specialization in Research and Health Administration, in the School of Public Health at the Central University of Ecuador. He also studied an MA in Anthropology at the Latin American Faculty of Social Sciences (FLACSO, in Spanish), in Quito, and a Ph.D. in Culture and Society in the Andes, at the Centre Bartolome de las Casas, Cuzco, Peru. At the present, he is the coordinator of the program of “Traditional Medicines and non-formal Health Systems”, at the Andean University Simon Bolivar.
confident about what will be the point of arrival in resolving a disease, because for them that is uncertain”, Mideros said in an interview.

However, Mideros calls attention on differences in the biomedicine, because “in this context doctors usually say that they know the point of arrival”. From this analysis, Mideros believes that the proposed “intercultural health” closely resembles the thinking and theories of biomedicine, because it proposes the creation of an intercultural model, instead being an approach consistent with the worldview of Andean indigenous people.

Despite the various classificatory schemes devised by anthropologists who recognize the diversity of medical systems in complex societies, the study of medical pluralism had reached a theoretical impasse. As Brodwin affirmed: "Attempts to categorize plural medical systems often produced rigid functionalist typologies or broke down in a welter of incomparable terms" (Brodwin 1996: 1). That is why some medical anthropologists have turned to concerns such as the political economy of health,28 biomedical hegemony, and alternative medical systems in Western societies, reproduction, the mindful body, and the social dynamics of clinical encounters.

2.1. (Local) Indigenous Knowledge

The inhabitants of Andean villages and cities are no longer viewed as passive and suspicious victims of supernatural and harsh environmental constraints, rather they are resilient, persistent, and engaged in maintaining their well being in a complex setting through a variety of means.

We must not overstate the case yet. Andeans are up against tremendous odds in their attempts to maintain health because of the very same political, economic, environmental, and social conditions imposed by inequality and poverty.

In Andean countries, as Bolivia and Ecuador, the land reform and the elimination of the hacienda system stimulated the growth of local peasant markets and a drastically reduced of indigenous dependence on the mestizo class. These changes also destroyed the economic base of the rural mestizo, specifically the extraction of indigenous resources and labour (Carter 1964; Dandler 1969; Heath 1969; Malloy 1970).

This notion has justified mestizo economic and political super-ordination and control of the indigenous population. Therefore, the destruction of "mestizo" economic and political control over the local Aymara in the 1950s eliminated a "mestizo" sense of community in the village, since many people left the village for living in the city. This situation was clear in Ecuador, for example, between indigenous Kichwa Otavalo and "mestizo" people who lived there.

28 Various anthropologists interested in the political economy of health exhibited an interest in how power relations shaped plural medical systems.
Authorities of Jambi Huasi affirmed that in this health center the combination of treatments is avoided. This suggestion aims to prevent problems in patients like self-medication or over-medication due to compliance with different treatments. This concern could be linked with one of the major concerns expressed in the medical anthropology literature, about pharmaceutical use: the issue of self-medication or self-care (Logan 1983; Price 1989; Van der Geest 1987); which can be linked to cultural meanings about health, illness, and disease; as Blesdoe and Goubaud (1985) said. This problem was confirmed in Ecuador by Price (1989), who contended that in this country the practice of self-medication is consistent with popular understandings about how illness should be managed (Finerman 1983).

According to van der Geest and Whyte, medicines, defined as "substances used in treating illness," are "charms" that act as important vehicles for imparting and communicating social messages (1989:345). Arguing that the worldwide popularity of medicines is not justified solely by their effectiveness, these authors use the concept of fetishism to contend that medicines are objects that facilitate "symbolic processes" (van der Geest and Whyte 1989:345).

Medicines are meant to heal so that the transfer of a medicine from one hand to another symbolically implies the transfer of healing powers as well. Pharmaceuticals carry with them potent associations of a powerful healing tradition that encompasses doctors, laboratories, and science, in other words "the power and potential of advanced technology" (van der Geest and Whyte 1989:361; Whyte and van der Geest 1988).

Medicines based on traditional indigenous medicine are generally less expensive than pharmaceuticals. Thus many hold the belief that a patient has little to lose by trying natural medicines, particularly if the medical problem is a minor one. But, as Miles (1998) said: "the popularity of natural medicine goes beyond issues of cost and accessibility and can be located in its proficiency in combining important and potent symbols from different, and sometimes even contradictory, healing traditions. (Miles 1998: 211)"

2.2. Biomedicine and Local Knowledge

Current themes in medical anthropology, an in Andean medical anthropology, recognize biomedicine as an ethno-medical representation of western systems of knowledge and while a dominant and often hegemonic force, it is also just one alternative from which individuals might choose.

Besides, the choice of one or more forms of healing within broadly pluralistic health system do not reflect degrees of rationality, but degrees of negotiation among myriad social forces including (or not) perceived efficacy of treatment.
Medical systems in the Andes are pluralistic incorporating a variety of indigenous specialists (including “curanderos”, bone setters, herbalists, and midwives) who practise among a population that also avails itself of biomedical practice ranging from self-care with the use of pharmaceuticals, to tertiary care hospitals.

Indeed, pluralism is increasing in the Andes, new practices are continually being introduced; sometimes driven by practitioners seeking new healing techniques and sometimes by more obviously commercial considerations. However, the issue of the compatibility between medical ideologies and systems or treatment options, which was once such a concern for scholars, seems no longer a relevant issue to anthropologists. (Koss-Chioino et al. 2003: 9) This last idea is linked with the proposal of “Complex Medical Systems”, proposed by Mael T. Luz.

About the relationship between local and biomedical practitioners, Pillsbury (1982) describes some early attempts at cooperation between them, but came to the conclusion that genuine cooperation to any significant degree was extremely rare. The discussion about whether the cooperation is desirable and feasible or not, still continues. Some researchers think that the underlying theoretical concepts are so odd that cooperation is practically impossible.

Other researchers have taken a more pragmatic view and have appealed for cooperation, because of the involved mutual benefits. Another point of view is that a closer relationship between modern and traditional medicine may endanger the existence of the latter as it could be engulfed by modern medicine. A more general opinion, emphasized by many anthropologists, is that practitioners of the local and biomedical traditions should have more mutual understanding and respect for each other (Hardon 2001: 21).

Steffan Ayora promotes this idea in his ethnography *Globalization, knowledge and power: local medicine practitioners and their struggles for recognition in Chiapas* (Ayora 2002). In this book, he analyses the situation of some local medicines practitioners, who feel the necessity to seek recognition by other members of local medicine as by cosmopolitan medicine.29

This book presents an interpretive and critical analysis of the strategies used by local medicine practitioners at the Highland region of Chiapas (especially in San Cristobal de las Casas) Mexico, to obtain recognition of cosmopolitan medicine.

According to Ayora, studying knowledge and medical practices in the context of cultural globalization demands a translocal and *multisituado* focus. This type of approach allows researchers to study the processes of production, distribution and consumption of knowledge and medical practices, as translocal and, moreover. It suggests how the processes of homogenization and heterogenization that characterizes cultural globalisation are intervening.

29 Steffan Ayora (2002) considers “cosmopolitan” the dominant form of knowledge, or the knowledge established as science. In this ethnography Ayora refers to the contrast between “local” and “cosmopolitan” medicines.
Ayora thinks that recognizing these intersections can also unmask the various medical knowledge, local and cosmopolitan, as cultural hybrid products (Ayora 2002: 22). From the perspective of this ethnography, parts of the difference and hybridism are fundamental concepts.

In his opinion, the concept of hybridization has a great ambivalence (Ayora 1999a & 2002). In The Location of Culture, Homi Bhabha declared that the ambivalence of the term hybridization is like a 'third space' in which critical speeches can arise. According to him, the destabilization of binary oppositions between 'modern' and 'traditional', or 'global' and 'local', arise from the recognition of hybridization. (Bhabha 1994: 37)

This argument suggests that the hybrid is not the intersection of two forms that are pure in the beginning; in contrast, recognizing what hybrid means is just recognizing that "different cultures confirm their purity and authenticity as strategies of legitimizing" (Ayora 2002:57). This author proposes to understand the concept "hybrid cultural" as a result of the combination of local/regional/cosmopolitan knowledge and practice. In his view, these two kinds of complex knowledge and practices are already hybrids - since its starting point - and each seeks to legitimize itself through a rhetoric based on authenticity, originality and purity.

It is necessary to admit, Ayora said, that local and cosmopolitan medicines are crossed by a series of imaginary, which attach to each medical complex a chain of meanings that contribute to fix a different essence.

By considering this analysis, the hybrid shall be conceived as a product of power relations that do not disappear in the mix but are kept and reproduced. In this context, the relationship between knowledge and practices of biomedicine and local knowledge (as the case of the Kichwa traditional indigenous medicine) can finally reproduce the power of the biomedicine, if the "modern" framework of meaning becomes more significant than the local one.

This trend has been confirmed in the current case study, during the fieldwork at the Jambi Huasi. In the context of this health center of Otavalo, we can say that the concept "hybrid cultural" is situated between two poles: biomedicine and traditional indigenous medicine.

The fact to deny those both poles creates the possibility to claim the knowledge of people which is subjected to the domination of the cosmopolitan society and culture.

Ayora also said that the hybrid of different medical systems is expressed in the articulation and mixtures of the imaginaries that define every form of knowledge and medical practice. So, this is exactly what can be observed in Jambi Huasi. In practice, the relation between biomedicine and traditional indigenous medicine in this health centre is showing hybridization, through the articulation and mixtures of the imaginary that define forms of knowledge/practices of these two kinds of medicines.
The Mexican case study selected by Ayora was situated in the context of cultural globalisation, in terms established in the discipline that comes from the work of Roland Robertson (1992, 1995), Arjun Appadurai (1996) and Jonathan Friedman (1994). In the light of this, Ayora preferred the distinction between local and cosmopolitan medicines.30

Some analysts have criticized Steffan Ayora for not having used the scheme developed by anthropologist Eduardo Menendez, on the Hegemonic Medical Model (in Spanish, Modelo Médico Hegemónico).31 But both, the analysis by Ayora as well as the analysis developed by Menendez, recognizes the existence of power differences between local and cosmopolitan medicines.

In his ethnography Ayora proposes a critical reflection that validates the concept of translocality, which suggests shifting temporal and spatial attributes that help us overcome the conceptual limits imposed by the local-global dichotomy. It also prevents representations of the locals as static and unchanging forms anchored in a definite territory.

Ayora argues that the notion of locality, although indispensable in anthropology, often inscribes or even locks up culture in time and space, thus contributing to the institutionalization of the global-local dichotomy. In contrast, and supplementing it, he thinks that translocality as a concept, requires the recognition of forms of cultural exchange where the relations among blurred local groups foster the production of cultural hybrids and the transcendence of dichotomies that focus in the local.

In his opinion, there are strategies through which local medicine practitioners are achieving recognition and respect as bearers of knowledge, useful for the members of their own social groups (Ayora 2002: 29).

As a conclusion, Ayora suggested that in multicultural societies (like Ecuador) is necessary to transcend the legal and formal recognition to achieve ways of recognition which, rather than tolerate, could respect cultural local practices and knowledge. He claims that the quest for recognition of local medicine practitioners in Chiapas was based on an ethical framework built from rhetoric of the right to equality and respect.

The experiences of the Jambi Huasi health center has been a little different from those described by Ayora because, according to most interviewed, the work of jambigkunas (people who provide services based on traditional indigenous medicine) has been supported by authorities

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30 This distinction is not a dichotomy, but refers to the range of possible combination forms that arise from multiple particularization what is universal and from the universalization what is particular (Ayora 202: 17).

31 Eduardo Menendez defined the Hegemonic Medical Model to characterize medicine force in the decade of the ‘60s. This model includes the set of practices, ideas and theories generated by the development of what is known as scientific medicine, which is identified as the only way to cope with the disease, both legitimizated by scientific criteria as well as by the State. He takes into account the biomedicine within this model (Menendez 1990).
of that center in Otavalo; unlike what happened in the case study analysed by Steffan Ayora in Chiapas, Mexico.

However, based on the fieldwork developed in the Jambi Huasi health center, I was able to realize that there is clearly a difference of opinion regarding the way in which the traditional indigenous medicine and biomedicine relate. Some people interviewed see collaboration; others see a process of subordination or incorporation of indigenous medicine into a biomedical hegemonic system.\(^{32}\)

For that reason, I have suggested to reformulate the main research question. At the beginning of the fieldwork, one of the main research questions was to analyse how biomedicine and local knowledge are deployed in primary health care provided by the Jambi Huasi health center. But, in the light of the data analysis (from the fieldwork and the reviewed literature), I thought it would be necessary to reformulate the main research question, as follows: How does the concept of "intercultural health" allow understanding the way in which different knowledge/practices of biomedicine and traditional indigenous medicine are related in the Jambi Huasi health center? Based on the analysis that will be generated with the answer to this question, another question would be: Has the relation between biomedicine and traditional indigenous medicine become hybridized in the practice of health care provided by the Jambi Huasi health center?

### 2.3. Intercultural health construction

In order to answer the question on how does the concept of "intercultural health" allow understanding the way in which different knowledge/practices of biomedicine and traditional indigenous medicine are related in Jambi Huasi, I will begin contrasting views about the concept "intercultural health", from the reviewed literature and interviews conducted during the fieldwork.

Based on the fieldwork of this research, it is necessary to analyse the relevance of the term "interculturalism in health" or "intercultural health", because it was one of the most commonly used by those interviewed. Hence, the analysis of this term would allow us to have a best understanding on the cultural context of Jambi Huasi.

According to Mirna Cunningham (2002),\(^ {33}\) "interculturalism is usually confused with multiculturalism, which implies the formal recognition of diversity but within a context of vertical power relationships and discrimination".

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32 About these problems there is more analysis in the Chapter 3 of this thesis.

33 According to her, interculturalism implies moving beyond the recognition of the existence of different cultures. So, interculturalism as a concept refers to action and communication among people of different cultures. It does not involve only a person or group in particular, but the entire society, in promoting knowledge and comprehension among all of the sectors that make up the society. This interaction implies participation across cultures, respect and solidarity. (Cunningham 2002: 2)
The Mexican anthropologist Eduardo Menendez explained that the interculturalism is not confined to relations between members of Amerindian groups and biomedical staff. Overspent the ethnic limits, Menendez said that this asymmetric interaction occurs in various situations such as poverty, inequality and social stigma.

Hence Menendez can not think intercultural solely in moral terms of respect, tolerance and cooperation. In his view, the "Interculturality in the processes of health/disease/care operates in an unequal context, in the following aspects: cultural, economic, social and even biological (where life expectancy is much lower among the subaltern classes)".

However, after interviews with researchers on social sciences and health, (such as Raul Mideros and Jaime Breilh, at the Andean University Simon Bolivar, in Quito), I have preferred to move from the theoretical analysis of this concept to the analysis of its implementation in practice.

To what extent is the approach of interculturalism possible in the health field?

Sometimes the interculturalism in health is only a letterhead of subordination to certain strategies of biomedicine, Raul Mideros opined.

"I do not believe that interculturalism in health is possible, if there is not a real recognition of the diverse knowledge and practices in health (...). Because, for working in health the recognition of both biomedicine and traditional indigenous medicine is necessary, because, otherwise, we would promote the evangelization of biomedicine", he added.

So, for working in health, he suggests to decentralize the efforts, "otherwise we run the risk of promoting only the evangelization of biomedicine". To explain his concern, he recalls the case of some midwives who disappeared in Peru, "because their skills were eliminated or absorbed by the formal system of biomedicine".

Jaime Breilh (who is an epidemiologist and director of the Area of Health at the Andean University Simon Bolivar, Ecuador) believes that the debate on intercultural in health has been depleted, "because many people talk about ancestral health knowledge only limiting it to the topic of ancestral therapies; but interculturalism in health is much more than that", he affirmed.

Indigenous Knowledge (IK)

The notion of Indigenous Knowledge is complex to define, due to a myriad of historical, socio-cultural, political and epistemological factors (Battiste 2002; Agrawal 2002). Nonetheless, the World Bank defines indigenous knowledge (often shortened to ‘IK’ by the World Bank) as that which is: “unique to a particular culture and society [...] the basis for local decision-making in agriculture, health, natural resource management and other activities. The IK is embedded in community practices, institutions, relationship and rituals” (World Bank 1998:1).
Notwithstanding the debate about the definition adopted by the World Bank, it is argued by many that critical (Laurie et al. 2005) efforts to revitalise and legitimise IK could serve to democratise and empower educational policy practices in some countries.

According to some social science researchers (Agrawal 1996, Fernando 2003, Brown 1998), who analyse the concept of Indigenous knowledge (IK), the distinction between indigenous and Western/scientific knowledge can present problems for those who believe in the significance of “indigenous knowledge for development”(Agrawal 1996: 1).

Arun Agrawal suggests that the attempt to create distinctions in terms of indigenous and Western is potentially ridiculous. For him, it makes much more sense to talk about multiple domains and types of knowledge, with differing logics and epistemologies. It is something of a contradiction—though an unavoidable one—that the same knowledge can be classified one way or the other, depending on the interests it serves, the purposes for which it is harnessed, or the manner in which it is generated.

“It is only when we move away from the sterile dichotomy between indigenous and Western, or traditional and scientific knowledge, that a productive dialogue can ensue which focuses on safeguarding the interests of those who are disadvantaged” (Agrawal 1996: 5).

Fernando (2003) and Brown (1998) agree with Agrawal’s thought. According to them, the so-called Indigenous Knowledge (IK) has become a means through which the diversity of knowledge systems and the embedded cultures in which they exist are disciplined and managed according to capital’s need to expand.

“The collaborative role played by the nongovernmental organizations (NGO’s) in this process is obscured by their use of the seductive language of empowerment of marginalized social groups. NGO’s interventions run counter to the interests of the people they claim to serve. The challenge to work towards an alternative institutional environment that could liberate the use of IK from being determined by the ideology and institutions of capitalism” (Fernando 2003: 1).

Brown (1998) analyses this topic from a skeptical assessment of legal schemes to control cultural appropriation. He believes that although there are compelling reasons to be skeptical of some indigenous intellectual property rights proposals currently under discussion, he strongly supports efforts to create basic mechanisms for the compensation of native peoples for commercial use of their scientific knowledge, musical performances, and artistic creations.

In his opinion, equally necessary are clear guidelines for the collection of culturally sensitive ethnographic data and potentially marketable human biological materials, including cell lines. “I would hope, too, that anthropologists will continue to register objections to the patenting of medicinal and agricultural plants discovered or domesticated by indigenous populations and used by them for centuries” (Brown 1998: 204).
Because the international sponsors of *Jambi Huasi* have come especially from systems of international cooperation of other governments, than from NGO's, and because that aid has focused more on specific programmes (such as reproductive health) than in primary health care, this research has not focused on this interesting dilemma.\(^{34}\) However, this topic has been taken into account in interviews regarding *Jambi Huasi*.\(^{35}\)

"Behind all, the term 'Indigenous Knowledge' is one of those expressions that are in the same dominance as ever. As the world changes, as cultures and indigenous peoples arise throughout the world, then there are organizations that generate a replica and a new terminology that will allow them to return to resettle in power", Jaime Breilh opined in an interview.

He criticized the work of organizations that use only the image of indigenous people for working with a vision aligned to other interests. "I think that it is not only an ethical problem, it is not that there are people who do that because they are ethically wrong or bad, but because they were trained in universities with scientific paradigms that lend themselves to that". Breilh also criticizes the fact that the World Bank has hired people to devise certain categories, such as Indigenous Knowledge, "in order to garnish the way".

**The role of communication**

"Ignorance regarding the indigenous vision of the world; communication in Spanish language to Kichwa speaking communities and discrimination to indigenous were the limits preventing a respectful rapprochement and the obstacles to an intercultural dialog". (Conejo et al. 2006: 32)

The work of the *Jambi Huasi* health center involves communicating concepts and practices based on biomedicine and traditional indigenous medicine. In this research has also been considered relevant literature on communication of science and medicine, regarding to this research proposal.

The majority of projects designed for communicating science, technology or medicine follows models of an asymmetrical type, like those of deficit or diffusion (Lewenstein 2003: 3). They are limited to models which analyse communication as a process with a unidirectional path, moving from the scientific to the public, or from the physicians to the patients (in the case of the medicine). Those models assume that the transmitted information is neutral and ignore the cultural characteristics of actors. These could be the main reason why communication between physicians and patients sometimes is problematic (Wynne 1996: 46)

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\(^{34}\) The directors of *Jambi Huasi*, Myriam Conejo, has informed me that the financing of NGO's in these centers finished approximately two years ago, and that it was more focalized in the specific programs (such as reproductive health), than into primary health care (which will be in the focus of this research). She also has informed me that international sponsors of *Jambi Huasi* have come especially from systems of international cooperation of other governments, more than from NGO's.

\(^{35}\) Because I'm interested in the debate around this theme, I will include this analysis in a future research.
One aspect that has been particularly invisible in recognition of this practice, according to Perez-Bustos, has been the experience of those who are mediating the communication of medical knowledge, as well as implications of such mediation in the process of building knowledge. In this sense, aspects of how the different kind of health care has generated subjectivities have been little explored regarding the dimension communicative/educative of communication (Perez-Bustos 2008: 2).

Speaking of the doctor-patient relationship, Rosa Gomez-Esteban said that in this relationship, within the own medical act the areas of the personal and the subjective are combined, one part as much as the other (Gomez-Esteban 2002: 70). However, she clarified that this dissonance and conflicts are repeating in public and private health systems too often. She believes that such gap or open wound is offering feed-back -within a vicious circle- “to an academic medicine which acts defensively and to some patients who have lost confidence in the person that will help restore their health”.

If we accepted that dialogue will have to be cultural, then the traditional unidirectional model of the communication of medicine will have to be reformulated from the socio-cultural perspective, to become a more complete model. This new model of communication takes into account the connections between forms of organization of the society (the politics-cultural), socio-economic mediations and cultural characteristics of actors.

“Communication has a very important role in Jambi Huasi, because it promotes a good relationship between the people who work here and from this center with society”, Azalia Vasquez, a psychologist from Jambi Huasi, affirmed in an interview. As strategy of communication, Jambi Huasi presents every Monday a programme on health through Radio Iluman, both in the Spanish language as well as in Kichwa. Jambi Huasi has also developed videos, brochures, reports on television and other media. Moreover people participate in various conferences or seminars, to share with others the experience of this health center.

Although some physicians or biomedical professionals want to achieve a global projection, they have to acknowledge the local cultures before communicating with the general public. Fayard summarises this point with the bellow opinion: “If science is global, its measurement, to be efficient, ought to be developed locally. Think globally, act locally” (Fayard 2002: 238).

Communicating is to dialogue, is to relate a fact to the cause that produces it and with the effect that it generates. In this research the communication process of the biomedicine and local knowledge has been understood as a socio-cultural practice that operates between biomedicine professionals and jambigkunas (people who know and practice traditional indigenous medicine), and between them with patients of Jambi Huasi, in primary health care.
In this regard, health workers that speak the language and understand local customs can be critical to delivering quality care. For this reason, 8 years ago, *Jambi Huasi* employed a full-time communication and education specialist, Mercedes Muenala, who has a degree in internal medicine from the Central University of Ecuador and, at the present, she is coordinating the Intercultural Health Area, at the Provincial Health Direction of Imbabura.

When Muenala worked in *Jambi Huasi*, in the Sub Area of Education and Communication, she spent a lot of time talking to women and men in Kichwa communities in an attempt to increase awareness of reproductive health issues. With her team, she developed activities such as training workshops of midwives ("parteras" or *mamahuas*, in Kichwa), health volunteers and teenagers.

According to Jaime Breilh, communication plays a fundamental role in promoting or misrepresentation of the process of interculturalism in health.

Recently there have been some reflections on the need to think how the recognition of new or other ways of knowledge production in health care deserves the setting and recognition of other forms of communicating (Barrio-Alonso 2008). In the new forms, patients are recognized as an actor involved in these developments and not just as the final user or as a mere consumer of them.

Through the analysis proposed by Steffan Ayora, about the concept of hybridization, I believe it is necessary to change the conception of intercultural relations. Until now, the rhetoric on multiculturalism remains dominated by the idea of tolerance, implying inequality, because it assumes that one part has the power to "tolerate" the other.

I agree with authors like Ayora (2002), Taylor (2004) and Honneth (1995 meetings, 1995b), who prefer to go beyond tolerance, when analysing the relationship between biomedicine and local knowledge. Instead of tolerance, the proposal would be to promote the acceptance and respect from each to other cultural forms. Only through this acceptance, validity and a not changing recognition of medical knowledge and cultural otherness, it will be possible to foment an "intercultural construction of knowledge".
3. PRESENTATION AND ANALYSIS OF DATA

3.1. The beginning and development of Jambi Huasi

Which were the political, social and cultural conditions which made historically possible the emergence, permanence and consolidation of initiatives and projects on alternative medicine in Imbabura, such as Jambi Huasi? How did the idea of creating Jambi Huasi in Otavalo emerge? I will try to answer these questions in this section.

The Indigenous and Peasants Federation of Imbabura (FICI, according to its Spanish abbreviation) was the engine that promoted the creation of Jambi Huasi, as an answer from the indigenous organizations to the lack of attention to the right to health of indigenous people. (Conejo et al. 2006: 26).

How was the FICI created and what were its proposals concerning health? During the past and the current century, the indigenous Kichwa population located in the Imbabura province have had a significant social and political role. One of the first organisational attempts was the creation of the Ecuadorian Indigenous Federation (FEI according to its Spanish abbreviation), in 1926.37

Subsequently, the Ecuadorian state policies tried to eliminate any kind of pre-capitalist relation; to fix wages; to incorporate more efficient productive techniques; to enlarge cultivated fields; to eliminate the country estate (hacienda, in Spanish) and to improve the social and economic living conditions of the country men.

In order to promote the development of indigenous communities, a set of assistance programs addressed to the poorest rural sectors, was implemented. At the beginning, International Cooperation Organizations intervened, but then the Ecuadorian State took over, in all indigenous population areas, especially in the Andean region.

Concerning the issue of health, it was thanks to the support of the organization “Mision Andina” that a “health relay” model took place; it offered medical training to the community members. (CONAIE, 1989)

However, discrimination to indigenous people –from the part of “metizos”– was a deeply generalized attitude in Ecuador, which was also expressed in health centers and hospitals. That is

37 At the beginning, the biggest concern of this Federation was land lawsuits and the settlement of wages to workers in all country estates. Then the Kichwa language was included as a subject in all schools and high schools, a fact that gave beginning to a political process of reasserting the indigenous identity nationwide. In order to establish a relation with other provinces, to know about organizational initiatives and their perspective, in 1972 the ECUARUNARI was created in Ecuador and, in 1973, the Indigenous Organizations Provincial Coordinating Committee was founded.
why most of the indigenous people were not attended respectfully when requiring medical assistance; they were bad treated and discriminated in many ways.  

"At the hospital, indigenous people did not have appropriate attention. In some cases, patients were not registered or cared for. Their treatment was never equal than for white and ‘mestizo’ people". (Tamayo: 1996)

Relationships between indigenous patients and medical staff were marked by cultural gaps but mainly by attitudes of intolerance and ethnocentrism. (Mideros et al. 2000: 5)

"In the past, we as indigenous people have been mistreated. It was believed that the indigenous did not count and that only the ‘mestizos’ had value (...). They treated us with disrespect. The same happened in the health services, when we went to the hospital. We as indigenous were deprived of a respectful treatment. Due to all of this we started to organize ourselves", Vidal Sanchez, an indigenous herbalist, said in an interview.

Such discrimination "promoted the accentuated separation between the two health systems, apparently irreconcilable: biomedicine did not accept indigenous health practices and this practice took place, in a forbidden way, inside the communities. Furthermore, some indigenous people did not have access to health services". (Mideros et. al. 2000: 5)

Some religions made an attempt to intervene in this subject: “evangelizing health”. The Catholic religion affirmed that in the practice of traditional indigenous medicine there were some idolatry signs. Other religions missionaries and protestant sects also pretended to eliminate such indigenous superstitions. In Otavalo, some indigenous communities have found in the evangelist religion the support to be literate in Kichwa and since then, these indigenous recognize in Protestantism the value of freedom; through this religion they began to appreciate their language and culture (Rohr 1991: 99-100).

**The relation of FICI with Jambi Huasi**

In the 1960, the Ecuadorian government gave importance to the execution of social policies, particularly in the health area. In 1972, a year of compulsory rural service was established for all recently graduated doctors, so they brought their services to rural populations.

"As a consequence, the operative structure of the Ministry of Public Health showed its growth, mainly in its units of lower complexity and accordingly to the implementation of the Rural Health National Plan and with the approach of community medicine and, subsequently, Primary Health Attention". (Suarez 1987)

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38 This is the opinion of several people that I met during my fieldwork in Otavalo, Ecuador, such as: Myriam Conejo, director of Jambi Huasi; Javier Teran, director of the San Luis of Otavalo Hospital; Olga Farinango, director of the Health Area in the Municipality of Otavalo and former physician of Jambi Huasi; Mercedes Muenal, coordinator of the Intercultural Health Area in the Provincial Health Direction of Imbabura; Vidal Sanchez, herbalist and former worker of Jambi Huasi; Javier Perugachi, yachak of Jambi Huasi; Leandro Prieto, physician and researcher at the Andean University Simon Bolivar; among others.
But "the sanitary services expansion could not satisfy the needs of medical attention; moreover, that sort of programs did not help community participation. The old health stereotypes survived all good intentions; the vertical planning on health actions continued without taking into account the opinions of Kichwa people. The persecution of Kichwa traditional medicine specialists was intensified, and fighting against the cultural health system became a civilizing task needed to 'get out of backwardness'. However, the medicalization of rural health faced great resistance in the way of communitarian life and the strength of local beliefs. (Mideros et al. 2000: 10)

In this context, the first actions promoted by the Indigenous and Peasants Federation of Imbabura (FICI, in Spanish) were directed to procedures and claims before the state health instances, in order to improve or to expand their health operatives and services, and to stop the persecution of specialists Kichwa.

The FICI “had gained significant experience, as a result of its actions and relations with state programs, but mainly it had acquired ability over the life situations a community went through and over the inefficiency of the health programs promoted by the Ministry of Public Health. Those aspects were benefited by the presence of a Kichwa indigenous graduate as doctor, who, since 1983, took part of the health actions developed by the FICI”. (Mideros et al. 2000:14) In this way, the FICI became the engine supporting the creation of Jambi Huasi.

This Federation proposed to combine the knowledge and techniques of Kichwa traditional indigenous medicine with those of biomedicine. Its political speech, since the 1980s, remarked the “rescue” of the indigenous identity.

In November 1983, the FICI formally started its health action, supported by the international financing of the Canadian Fund —which is a specialized agency of cooperation to indigenous populations. Since then the health area of FICI got the name of Jambi Huasi, which means Health House in English.

Between 1983 and 1984, Jambi Huasi's service were based on two actors: the indigenous medicine practitioner (who also used allopathic medicine) and the yachak tayta (who used the Kichwa traditional indigenous medicine).

When the FICI received the financing of the “Organization Catholique Canadienne pour le Developpement et la Paix”, Jambi Huasi widened its services, even though its management and direction followed centralized in the FICI.

In 1987, Jambi Huasi provided medical attention in the fields of general medicine and paediatrics, dentistry and nursing. It also organized activities of training for health promoters.

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39 Health was one of the approaches that supported the process of constitution of organizations born before, simultaneously or after to the FICI.
Later on, *Jambi Huasi* had a multifunctional system, with services and activities directed to primary health care for communities. However, these functions and services did not have stability and permanence; these depended on the financing to cover costs of operation of this system.

The health problems covered by *Jambi Huasi* are not just focused on the problems affecting the population; through time, *Jambi Huasi* staff has identified that some problems are related to the co-existence of culturally different systems of comprehension of health and illness.

“In our reality there are two health systems: one is formal, western, state; and another is non-formal Kichwa, traditional. Both systems are in conflict, one for imposed and the other to survive. But in this reality of misery and exploitation, it is possible to rescue the values, criteria and most positive experiences of each one of the systems”.

“Not only graduate doctors were in charge of attention in the communities, but also the *yachak tayta* and the *kakuk tayta*. This kind of mixed activities suggested an issue, still with no answer: about the institutionalizing of the attention provided by Kichwa health agents” (Mideros et al. 2000: 17). Therefore, during its first operation years, attention to health problems of the communities was the main objective of *Jambi Huasi*. Its goal was to give health care to remote indigenous communities.

Nevertheless, “all projects, activities and decisions were centralized in the Government Council of the FICI. The concentration of functions in a few leaders was the cause of the slowness in the management of resources to execute projects in a direct way. Furthermore, there was a lack of coordination and direction in the organization”. (Mideros et al. 2000: 20)

This was one of the main causes for the distance between the Health Area of the FICI and the rest of this organization, which caused the weakening of *Jambi Huasi* in 1987. Despite these problems, *Jambi Huasi* continued working until 1992, but in that year it could not give more service due to a lack of resources and the political and administrative crisis of the FICI. Since then, the administrative autonomy has been one of the requirements of people who have been in charge of *Jambi Huasi*. Initially, these aspirations were cause of political conflicts inside the FICI; but, in 1992, this Federation authorized the administrative autonomy to the team of *Jambi Huasi*.

What were the lessons learned during the first period (1984-1992) of functioning of *Jambi Huasi*? According to the team of *Jambi Huasi*, the main learning lessons in this period were:

- "Despite its initial motivation (1984 – 1992) for generating a multicultural health proposal, where the biomedicine and the traditional indigenous medicine could be complemented, in

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40 This view was part of discussion in a material presented at the “Fourth Provincial Congress of the INRUJTA-FICIP”, which was held from 13 to February 16, 1986, in the community of Huaycopungo, in the Imbabura province (Quoted by: Mideros et al. 2000: 17)
practice the discrimination context led us to create a service of indigenous people for indigenous people".

- "A model exclusively created for the indigenous population did not make easier the promotion of a multicultural model which could be efficient in terms of health attention in localities with diverse population, and which could be easily incorporated in the services of the Ministry of Public Health. In this stage, the recognition of the jambigkunas (people who offered health services based on the Kichwa traditional indigenous medicine) could not be reached".

- "Most part of the Jambi Huasi users was women but we did not have an answer to their needs in reproductive health and we had no idea of how to do it".

- "Free charge services did not give any guarantee to the institutional sustainability and, instead of being a factor bringing the users closer; it went against the principle of reciprocity (which means Kamary in Kichwa). This aspect encouraged paternalism and political ‘clientelism’ in the community”. (Conejo 2006: 36).

To overcome these problems, in 1992 the FICI entrusted the health activities of the Jambi Huasi project to a professionals team, to work with both the Kichwa traditional indigenous medicine services as well as with biomedical services.

Later on, the team of Jambi Huasi had the opportunity of elaborating alternative proposals directed to find health solutions based on the knowledge and reality of the indigenous people, mainly indigenous women. To implement these proposals, they asked for financing of the United Nations Population Fund (UNFPA).

The support of UNFPA was approved in October 1994. In order to accomplish the assumed commitment with this international organization, the new board of the FICI established the following objectives: implementing a health house with trained staff in the philosophy of attention and service; doing a cultural conduct study about pregnancy, childbirth and family planning; doing workshops with the FICI; encourage the sow of medical herbs in the communities; and do a research about Kichwa traditional medicine and herbs use”. (FICI 1994)

Once the resources of UNFPA were paid out, the FICI entrusted the execution of the Jambi Huasi health project to the “Utopia Foundation”.41 But in January 1995, the new FICI board claimed the right to completely manage the Jambi Huasi project, since they considered that “Utopia Foundation” did not put into practice the agreed guidelines.

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41 Then, the team work was mainly composed by “mestizo” professionals: two doctors, a manager, an educator, a midwife, an auxiliary and a janitor.
Then, the FICI designated Dr Myriam Conejo as coordinator of the *Jambi Huasi* project. This Federation also named a *yachak* and a nurse as the first technique staff of *Jambi Huasi*. Subsequently, the indigenous doctor Olga Farinango got part of this team.\(^{42}\)

About this time, Myriam Conejo remembers: “The presence of indigenous doctors trained in western medicine (biomedicine), but with a strong identity and vision of the indigenous world, was a key factor to discuss and define the service, as a multicultural service. Parallel, it a process of health promotion took place, communitarian visits”. Conejo affirmed that the goal of these visits was to watch and share experiences; to establish a dialogue with people of indigenous communities, so they can recognize and exercise their individual and social rights. “The goal was to promote the exercise of citizenship in daily spaces”. (Conejo 2006: 39)

In January 1998, *Jambi Huasi* achieved its corporate body under the name “Foundation of Alternative Medicine, Jambi Huasi”.\(^{43}\) With the purpose of integrating two health systems, the *Jambi Huasi* team has faced some tension and disagreements inside as well as in its relations with other health services, especially with biomedicine.

What were the lessons learned during the second period (1994-2005) of operating of the *Jambi Huasi* health center?

According to the team of *Jambi Huasi*, the main learning lessons during the second have been:

- “A multicultural service must consider heterogeneous populations, beliefs, culture, vision of the world and accept those differences without underestimating them”.

- “The demand of indigenous populations to access to health services is not just a matter of expanding the health coverage, but also of improving the quality of services, good treatment and respect to the culture. To indigenous people, the concept of health is not only absence of pain and illness; for them, health is to be in harmony, in an internal and familiar balance as well as with the community and nature” (Conejo 2006: 42). The understanding of and respect for this vision is one of the main characteristics of the traditional indigenous medicine, according to the Communication department director of the Public Health Ministry, Elizabeth Núñez.

- “A multicultural service is not only worried about the adaptation of services (...). It is about overcoming the limits, which have basis for a long time of racist prejudices, such as: idiomatic difficulties and a disrespectful treatment to indigenous beliefs or to indigenous people just for their ethnic origin; and the lack of humanity, respect and privacy in attention”.

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\(^{42}\) In this new stage, *Jambi Huasi* gave services based on biomedicine (through two graduate indigenous doctors), and on traditional indigenous medicine (through two *jambigkunas*, a midwife and a *yachak*); in addition to a dentistry, drugstore and herb medicine.

\(^{43}\) In Spanish: “Fundación de Medicina Alternativa Jambi Huasi”.  

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- "The right to the quality of attention, taking into account the indigenous identity and their point of view, is also expressed in the way how 'service lenders' and 'service borrowers' establish their relations daily (...). If the community understands health services beyond a healing space, but also as encounter spaces, learning spaces and motivation spaces, then a new understanding of health would be possible, considering the right and responsibility of all actors".

- Although the Jambi Huasi health center is identified as a non profit organization, a minimum fee was established, which allowed it a gradual cost recovery. The ranti ranti (which means give and receive) is a common and daily practice in indigenous communities; and, in Jambi Huasi, the relations between persons who provide services of traditional indigenous medicine and patients still are based on the indigenous principle Kamari or reciprocity. (Conejo 2006: 42 - 43)

**Integral health care for women of Imbabura**

In 1995, with the support of UNFPA, the Jambi Huasi center applied the so-called project "Integral Health Care for the Indigenous and Peasant Women of Imbabura". To achieve this, the staff of Jambi Huasi tried to complement services based on biomedicine and traditional indigenous medicine through the obstetric care.

This complementation was an attempt to rescue confidence in the work of midwives, considering the role they have in their communities; in addition to ensure a institutional service with technical response capacity, and with a referral system in cases of obstetrical complications. For doing so, "it was necessary to develop an intern referral system among the 'lenders' of health care of the two systems". Conejo added that this process was personalized and made the limits of both methods clear, to guarantee the quality of the attention and the credibility. (Conejo 2006: 48)

**Training for teenagers and teachers on sexual education**

During its first period of community visits, from 1995 to 1999, Jambi Huasi also offered medical care and dentistry services in schools of 10 communities.

In 2000, a team of Jambi Huasi trained 300 teenagers on sexuality subjects. This training was in Kichwa and Spanish. To guarantee the teenager's training, Jambi Huasi also offered training to teachers and it developed materials suitable for the cultural and ethnic reality of Kichwa indigenous teenagers. But, because of a lack of financing, those visits were cancelled since the 2005. Now, Jambi Huasi offers its services only in its establishment located in the city of Otavalo.

**3.2. Characteristics of the patients flow**

The staff working in Jambi Huasi reported that in the early years of this health center, patients of traditional indigenous medicine preferred to arrive to the center at night hours or very late, the
reason was that they did not want to be seen and criticized by others, due to the idea that the traditional indigenous medicine (especially the work of yachak) is useful just to hurt someone.

The director of the San Luis of Otavalo Hospital, Javier Teran, recalls this impression, of the period when he worked at Jambi Huasi (more than four years ago): “In the past, people avoided being seen in Jambi Huasi, they feared to be misjudged, due to the fact that traditional indigenous medicine was not recognized or valued at that time. Instead, as Jambi Huasi has managed to institutionalize traditional indigenous medicine, now people visit Jambi Huasi regularly”. So, over the time, most patients prefer to arrive early at Jambi Huasi, without fear. Currently, patients arrive since 08h00 searching for a turn.

Current Schedule of services in Jambi Huasi

<table>
<thead>
<tr>
<th>Biomedicine</th>
<th>Schedules</th>
<th>Tradicional indigenous medicine</th>
<th>Schedules</th>
</tr>
</thead>
<tbody>
<tr>
<td>General doctor</td>
<td>8H30/17H30</td>
<td>Yachak</td>
<td>8H30/17H30</td>
</tr>
<tr>
<td>With prior appointment</td>
<td>With prior appointment</td>
<td>Jakug</td>
<td>8H30/17H30</td>
</tr>
<tr>
<td>Dentistry</td>
<td>8H30/12H00</td>
<td>Mamahua</td>
<td>8H30/16H30</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>8H30/17H30</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical Laboratory</td>
<td>8H00/12H00</td>
<td></td>
<td>14H30/16H00</td>
</tr>
</tbody>
</table>

During my fieldwork, I was able to access to reports related to the consultation of patients in Jambi Huasi, during the period 2nd – 27th June of 2008. At that time, it was possible to gather information related to 616 patients. These data were delivered in Jambi Huasi by biomedical professionals and jambigkunas (who provide health care based on traditional indigenous medicine). Based on these data, it has been possible to develop some graphics that are exposed in this section and which illustrate and/or confirm analysis presented in this thesis, as the following:

Language of patients who visited Jambi Huasi in June, 2008

![Language of patients who visited Jambi Huasi in June, 2008](image)

On Thursday, yachak and jakug work until 13:00 and, on Saturdays, until noon. The partera (midwife) works from Monday to Friday. She has skills as “fregador” and she also can do diagnosis and cleaning with a guinea pig. Furthermore, she usually cures the so-called “mal aire” and “susto”. The jakug also has experience as a midwife. In this way, the timetables set by Jambi Huasi ensure to the patients that all services are covered all along the week.
Most people who live in the canton of Otavalo are of Kichwa Otavalo, Kichwa Kayambi, and "mestizo" origin. Although the official language in Otavalo is Spanish, most indigenous people also speak Kichwa. Some bilingual people prefer to speak in Kichwa during their consultation with the yachak, jakug and "partera"; because their original language is Kichwa. The proportion of the indigenous population inhabiting the Imbabura province is significant, since it accounts around 40% of the total population. (Conejo et al. 2004: 5-6).

Language is fundamentally important to indigenous health, both in terms of its use as a predictor of all things indigenous and as a medium for transmission of knowledge within cultures and health care. (Montenegro & Stephens 2006: 1859).

In this regard, the physician Olga Farinango\textsuperscript{45} thinks the advantage of speaking Kichwa and being an indigenous woman helped her to establish a good relationship with her patients.

Observational data also indicated that there are more women than men as patients in Jambi Huasi. To confirm it, see the following graphic:

\begin{figure}[h]
\centering
\includegraphics[width=0.5\textwidth]{patients_gender.png}
\caption{Patients of Jambi Huasi in June 2008, according to gender}
\end{figure}

According to Hinrichsen (2000, 2006), Jambi Huasi is unique, because it provides biomedicine and local medical treatment, as well as family planning advice and services. This combination of services has made of Jambi Huasi a very popular health center for indigenous people and "mestizo" people.

The range of services of Jambi Huasi is extensive. It has an examination room, a lab for blood work, a dentist’s office, a pharmacy which dispenses both modern and traditional medicines, a program of information and education, and outreach services, which have included an ambulance to bring emergency cases to the local center.

\textsuperscript{45} Currently, she is director of Health Area in the Municipality of Otavalo. In Jambi Huasi, she worked as physician in the period 1995–2000. She studied medicine in Cuba.
During the fieldwork, the demand of patients was higher for services offered by the three *jambigkuna* ("partera", "fregador", and *yachak*) that for those of the doctor. Such information could be confirmed through the following graphics:

![Patients of Jambi Huasi in June 2008, according to services received](chart1.png)

So, about half of *Jambi Huasi*’s patients use the services of local medicine practitioners. For most patients interviewed in Otavalo, the success of *Jambi Huasi* arises of its integration within the cultural traditions and the value system of them. This idea was also announced by Hinrichsen in the following words: "An important characteristic of the demand of *Jambi Huasi* is based on the delivering health care in a way that respects values and beliefs of patients". (Hinrichsen 2000: 3)

![Patients of Jambi Huasi during June of 2008, according to the kind of treatment practiced](chart2.png)

The health problems covered by *Jambi Huasi* are not just focused on the problems affecting the population; through the time, *Jambi Huasi* staff has identified that some problems are related to the co-existence of different cultural systems of comprehension and explanation of health and illness.
During the fieldwork, a surprising fact was noted. In Jambi Huasi most indigenous patients prefer the health care services of the biomedicine. Instead, most part of “mestizos” coming as patients to Jambi Huasi prefers the health care services based on traditional indigenous medicine.

This fact was evident during my observations, the interviews I did with physicians (of the biomedicine) and traditional indigenous practitioners of Jambi Huasi, as well as it was for a research report developed by researchers of the Andean University Simon Bolivar in 1998-1999.

Why do these preferences exist? According to the physicians and indigenous practitioners of Jambi Huasi, this is because most patients arrive to this center after trying with their own medical alternatives. The Mexican anthropologist Roberto Campos Navarro also has this view: “A first explanation is that indigenous patients have their curators in their own neighbourhoods and communities, so they wish biomedical care in an adequate intercultural environment; while “mestizos” have (in Jambi Huasi) an area where indigenous medicine is endorsed and socially legitimized by the own sanitary institution”. (Campos Navarro-2004: 144)

The physician Leandro Prieto also shared his experiences as doctor in Jambi Huasi: “During my experience as rural doctor in Jambi Huasi (five years ago) I realized that the joint of the biomedicine and the traditional indigenous medicine is possible (...). I also checked that in this health center there are more indigenous patients looking for biomedical services and more “mestizo” patients who wanted to be attended by an indigenous medicine practitioner”.

But, according to the ecologist Cesar Cotacachi, the main reason of the preference of indigenous in the “conventional medicine” (or biomedicine) is the influence of religion. “Religion has also influenced in beliefs of indigenous people. I believe that currently, approximately 100% of Kichwa Indians of Otavalo are Christians: Catholics, Evangelicals or Mormons. Evangelicals

46 “Mestizos” are people who descend from Spanish and indigenous.
47 The objective of this research was to explore and to analyse the profile or characteristics of the traditional indigenous medicine in the Jambi Huasi health center. The specific objectives of this research were: systematizing the process lived in the Jambi Huasi center, with emphasis on the trajectory of the activities of the health project of indigenous women, and conducting a comparative study between the two medical systems that make up the supply of services in Jambi Huasi.
do not believe in the services of a yachak, so many evangelicals indigenous do not visit yachak in Otavalo, but they prefer to receive the health care of a ‘western doctor’ (biomedicine professional) in Otavalo or in other cities. The Evangelical Church is present in Ecuador since the Government of Eloy Alfaro\textsuperscript{48} and has influenced the change of attitudes and beliefs of many indigenous people of Otavalo”. It is the opinion of Cesar Cotacachi.

Another reason why many indigenous people opt for conventional medicine (or biomedicine) is because there are a growing number of indigenous doctors in hospitals or conventional health centers. For example, the director of the "San Luis Hospital of Otavalo" is an indigenous Kichwa Otavalo.

"Generally indigenous people are afraid or fear of western or conventional medicine. But when they are attended by other indigenous or with people who can speak their language (Kichwa) and who treat them with respect, then indigenous begin to trust and then they prefer the conventional health system (or biomedicine)". Cesar Cotacachi said during the interview.

The yachak of Jambi Huasi believes that more “mestizos” than natives consider his diagnosis and treatment as yachak. Why? “Because most of mestizos deal with pills, a fact that causes on them other kind of illness; they really look for the sort of heal alternatives that I can offer with my medicinal plants. By the contrary, most of natives do prefer the Western medicine”.

About this topic, it is important to highlight the following analysis, proposed by Libbet Crandon-Malamud: “Medicine is a critical domain to our sense of selves, infused with enormous power and riddled with different paths that access material and nonmaterial wealth” (Crandon-Malamud 1991: 205). Therefore, mixed reviews of outcomes or resort of various medical alternatives may reflect reality, but they also could reinforce Libbet’s principal conclusion that a cure is only one of many goals or outcomes of medical choice. "Coexisting, conflicting medical ideologies address diverse aspects of the biological and social etiologies of illness". (Miles & Leatherman 2003: 23)

It is important to consider that the population from Otavalo is itinerant; they have intense exchanges with other people and cultures. Due to their commercial interests, they usually travel to different countries. Otavalo is, somehow, one of the most cosmopolitan cities of Ecuador; and, for that reason, the perception of people from Otavalo about health and healing is also cosmopolitan.

"In short, I could say that the population from Otavalo is more difficult to deceive. They have good smell for business. Therefore, if the indigenous people go to Jambi Huasi in search of

\textsuperscript{48} Eloy Alfaro was president of Ecuador from 1895 to 1901 and from 1906 to 1911. He was the leader of the Ecuadorian Liberal Revolution; he fought since his youth until 1895, when the Liberals took power. He attributed the separation of the church and stated the implementation of many political and civil rights in Ecuador, like freedom of expression. He promoted the build of the first railway from Guayaquil to Quito; he legalized divorce, built public schools, and allowed civil marriage.
services from Western medicine (biomedicine), it is because they know that such services can offer them better solutions, with more possibilities and resources”, Mideros opined.

Understanding the relationship between Jambi Huasi and the Kichwa culture of Otavalo, would allow us to have the opportunity to redefine concepts like "cultural identity" or the conception about what "indigenous" is.

In the research that Mideros developed more than 10 years ago, the highlighted fact was that people who feel indigenous are those in the communities. "The others are not indigenous, they consider themselves people from Otavalo, and they know very well how to move within circles of power", Mideros recalled.

During my fieldwork in the Jambi Huasi health center, I also realized that some indigenous people who came from remote rural communities feel different with respect to indigenous people living in urban areas, especially in the city of Otavalo.

3.3. Working spaces

The treatment of jambigkunas (especially of the yachak) embodies powerful symbolic messages, that are linked to Kichwa indigenous traditions and, sometimes, also to religion. This is evidenced by the following experience that occurred in the office of a yachak at Jambi Huasi.

During my first fieldwork day in the Jambi Huasi health center, I met a group of people representing the Provincial Health Direction of Pastaza; they came in order to learn about the center’s interesting experiences which they would implement later in their own provincial health centers. In fact, they had been delegated to implement some intercultural health strategies in the province of Pastaza, and as a first step they decided to learn about the experience of Jambi Huasi. After visiting more than 6 health centers, which were located in different provinces of Ecuador, the leader of that delegation said that of all visits that they had had so far, the person who most positively surprised them was the yachak of Jambi Huasi, due to his personality and his good attitude toward the patients, a fact which is “so important” for the yachak.

Madel T. Luz underlined the importance of this relationship when she said that in any medical system, regardless of its rationality, much of its effectiveness is conditioned by the performance of the therapist. “This efficiency, in turn, depends directly on the relationship between the therapist and his/her patients. The symbolic element becomes the key when determining the effectiveness of complex medical systems”. (Luz 1996: 36)

About the symbolic messages in the working space of the yachak at Jambi Huasi, Javier Perugachi, his consultation room has a ritual space that includes various “sacred objects”, as he calls them. There are medicinal plants, stones of various sizes, images of saints, water, candles,
etc. In fact, the interview was held at that space, where I was able to observe different objects of
natural, religious and ancestral origin.

A curious issue was seeing a small statue of a Virgin dangled from the roof of that room; she
seemed to be hanged by a rope. When I asked him why he had hung a statue of the Virgin in that
position, he smiled and said: “it is rare, few people have noticed this image and almost nobody
has asked me what the statue of a hanged Virgin means to me. I decided to hang this picture in
that position because it represents the suffering that most women tend to bear in this world”.

Later, he referred to some passages from the Bible describing experiences of suffering of the
Virgin Mary. Through this explanation, the yachak expressed his belief in the Catholic religion;
an affirmation which was confirmed later, once he shared the following experience:

“When I receive in this consultation room a patient with any disease in a very advanced state,
who has only two or three more days of life, I inform about it to some of his/her relatives, so they
can prepare his/her farewell. In these cases, I think it would be a sin to charge my consultation
services; I prefer to return his/her money back and, in addition, I hand over a dollar to his/her
family, so they can buy a candle in my name and to light it during the patient’s funeral. These
cases really made me sad, but I am aware that there is nothing else to do; those experiences
happen at least once a year”.

This yachak affirmed that when he receives a patient with a serious illness, he asks the patient
to read the following prayer, written by him, because he is a catechism man:

“In the presence of sacred Jesus, God I find myself so weak and downhearted. I
cannot take it anymore; here I am before you, poor and unprotected, with no hope
or courage. It is only You who can save me, only You are my refugee whatever it
happens. You have never left me. Let me follow You, if Your hand leads me
nothing will take me away from your love. I offer You the past, the present and all
the good things in my life. I show before you all my sins. Take it all and do not
condemn me, take me as I am. Teach me to be with You, to lay my trust on You,
that You are my God. God of kindness and fidelity, the God who opens his arms
and hold me, You are the God that saves me. I have faith and I do not have fear any
longer because my strength and my joy are of my Lord”. (Prayer by the yachak
Javier Perugachi)

“I wrote this prayer with the help of some children, to whom I have taught catechism. This is
the prayer that I ask patients to read, especially to those with chronic or serious illness, to convey
them strength and determination to heal”, the yachak affirmed.

Is it advisable to concentrate in the same place people who perform diagnostics and/or
treatments through traditional indigenous medicine? Myriam Conejo thinks so, “in order to avoid
the prejudices that some people have in relation to the work of the Jambigkunas”, and to offer
different alternatives of health care in the same place.

The archives of Jambi Huasi show the many visits that United Nations missions and different
organizations have made to this place, to share experiences or to make internships. This health
center has also received missions of the Ministry of Public Health of Chile, El Salvador and Bolivia, as well as from people of different provinces of Ecuador, and of two former Ministers of the Ministry of Public Health: Asdrubal de la Torre and Edgar Rodas.

But not all persons who were interviewed during the fieldwork agree with the fact that *Jambi Huasi*'s headquarters are located in the city of Otavalo. One of the people who criticize this situation is Raul Mideros, who conducted a research on *Jambi Huasi* about 10 years ago. He recalls that he usually confronted Myriam Conejo (when she was his student in a program about adolescence, during his research of 1998-1999), with questions such as the following:

Why does she allow that *Jambi Huasi*’s management patterns and labour division were the same in formal health systems and in biomedical systems?

Why does *Jambi Huasi* have its center’s infrastructure in the city of Otavalo, if the needy indigenous communities live in more remote areas of that city?

During her administration, as the executive director of *Jambi Huasi*, she proposed to work in indigenous communities located in rural areas of canton Otavalo. This work was carried out since the late 1990s until approximately 2005.

Conejo said that these visits were suspended because the *Jambi Huasi* center lacked financial resources to continue financing the relocation of its staff to distant communities, and because "the Ministry of Public Health of Ecuador has the mayor responsibility for primary health care in all communities, not *Jambi Huasi*".

Matilde Farinango also believes that the place where *Jambi Huasi* is operating now is a sacred space. She also said that the place where the *yachak* has his room satisfies the required characteristics for his healing. "Therefore, *Jambi Huasi* and its health personnel are not in just any place", she clarifies.

However, she also shares the thought of some elderly indigenous communities, those who disagree with the fact that some *yachak* are offering their services in health centers located in the city. "Some elder indigenous persons believe that the group of *yachak* must work in their own place and space, where they have access to the plants and materials they need for diagnosis and treatment. That is why many elderly say that it would be better if the group of *yachak* offer their services in their own places (into indigenous communities), rather than in health centers".

According to Farinango, many elderly are reluctant to change their opinion because they think that talking about interculturalism should not promote mobilizing *yachak* or midwives to the cities. "Some old people believe that in the cities the *yachak* or midwives would work with another point of view", Farinango explained.
Dr. Teresa Jaramillo, who was the director of the Asdrubal de la Torre Hospital, in Cotacachi, also shares the view of some elderly indigenous; she approves the fact that midwives work in their own communities, but not in the hospitals.

Nevertheless, there are people who have another opinion. “We cannot ignore the knowledge of traditional indigenous medicine, which has existed throughout thousands of years. I think that it is not enough to respect it, but to acknowledge the work of each system and to join efforts for a common goal: to improve people’s health, to achieve the level of ‘Sumak Kausay’ (Kichwa term that means ‘Best life’). If people who know and practice traditional medicine want to work in a health center or hospitals in the cities, that decision will be awarded according to the reality of each community. But if there are others who prefer to continue working in their own communities and, from there, contributing to the system of ‘reference and counter-reference’, I support both proposals”, Matilde Farinango said.

The research developed by Raul Mideros more than 10 years ago in Jambi Huasi, also emphasized other reasons why the staff of this health center was not very satisfied with the working spaces. His views were confirmed through the following quotes:

“The hampik (or jambigkuna, who is based on the traditional indigenous knowledge to cure) compare their spaces with those for western physicians and they look themselves at disadvantage, either because of the size of the spaces allocated for them or because of the lack of interest in offering them a better condition. This makes them feel “the least”, like they “were not appreciated” and that they “are becoming useless” in Jambi Huasi. However, the health team is aware that the financial sustainability lies primarily on the revenue that they (the hampik) produce”. (Mideros et. al. 2000:33)

“In their official speech, authorities of Jambi Huasi recognize relations between the two medical systems. The leaders of this center claim that between doctors (biomedicine professionals) and the hampik there is a dialogue, a permanent learning through exchange of experiences, so ‘it is not just to put a yachak in the center but to develop each other mutually, with mutual respect, with guidance, counselling of each other, learn from each other, without seeking to impose’. (…) However, the hampik have expressed great dissatisfaction towards the circumstances in which they work. They use many comparisons to describe their situation within and in relation to other team members: Their clinics are compared with the ‘hole in the nose’, there is no place to offer services, or for keeping the medicines. But, in the area of western medicine everything is beautiful, arranged (…). We three (yachak, mamahua and “fregador”) are the least”. (Mideros et. al. 2000:35-36)

“The hampik compare their situation with that of a farm worker, perhaps because they are afraid to talk with those who they believe ‘studied’, because they (biomedicine professionals)
speak with difficult words and only in Spanish. According to the hampik, the business and personal relationships in Jambi Huasi are perceived as unfair. These people are under the gaze of others to whom they consider their superiors rather than their colleagues. The hierarchies are also expressed in the field of knowledge and practices”. (Mideros et. al. 2000: 36-37).

For the above reasons, Vidal Sanchez and Mercedes Muenala (an indigenous nurse who now coordinates the Department of Intercultural Health, at the Provincial Health Direction of Imbabura) they decided to renounce from the work they had in Jambi Huasi, more than 8 years ago.

The director of Jambi Huasi health center, Myriam Conejo, affirmed that from the Research Report developed by the Andean University Simon Bolivar 8 years ago she has implemented improvements and changes in Jambi Huasi and in the relationship between biomedical professionals and jambigkunas (practitioners of the traditional indigenous medicine).

This perception of change was also shared by members of the staff of Jambi Huasi; but, at the end of an interview, the yachak shared his dissatisfaction for his working space and his salary.

The yachak’s consultation room is of approximately 10 square metres, and it is located on the first floor of the Jambi Huasi’s house. Why has not the yachak asked for a larger office? “The yachak chose the location of this room, because he prefers to feel closer contact with the earth”, Myriam Conejo affirmed.

“No, it is not my home. I am as a visitor here and I should leave some day”, the yachak Javier Perugachi replied. Then, when he is consulted what changes he would suggest to Jambi Huasi’s authorities to improve his work, in a seriously manner, he answered: “During the meetings, we vainly talk about the subject, the situation does not change (...). We need to enlarge the house, to complement the lacks of all of us working in this center, to have a better communication, to avoid racist attitude in Jambi Huasi (...). The professionals who have studied (biomedicine), those who have a higher category, they have sometimes a racist attitude towards me, or try to play down my job. It is like they do not give any importance to what we have to say. This is the reason why I rather choose not to talk. I think this is why they do not pay me on time”.

3.4. Staff and financial administration of Jambi Huasi

During the first phase of Jambi Huasi (1983-1992), the project administration and the financial resources were conducted by the FICI, with the signature of the President, a leader of the organization, a financial administrator and the director. This process, however, had some inconvenient since for the health team it was, sometimes, difficult to contact the leaders of FICI—they could be out of Otavalo, in other provinces or outside the country.
For the director of Jambi Huasi, Myriam Conejo, it was so difficult to be in charge of this center if economically it depended on the presence of the leaders of the FICI. In such circumstances, she and the technicians who were working in Jambi Huasi organized themselves to propose to the FICI to delegate them the administration, with the pledge to submit an annual report of activities. This proposal was accepted, a fact that led to the decentralization of administrative autonomy of Jambi Huasi, until now.

After several years of service, this organization has managed to maintain its self-financing with the payment of consultations by patients and sometimes with the support of health projects funded by international cooperation agencies, such as UNFPA.

The principle of reciprocity has been a common feature in the practice of traditional medicine by indigenous Kichwa of Otavalo. “This principle is understood as the fact of providing health care that ensures quality, honesty of this attention, in exchange for a minimum fee in relation to what the private sector charges for providing its services”, according Conejo.

She adds that the process of self-financing, during her administration, has prevented the establishment of other kind of exchanges, such as barter with species, but “we have promoted the practice of solidarity with patients, to offer credit or free service to whom can not pay the cost of consultation or medication”, Darwin Tamba affirmed.

According to him, the main problems of Jambi Huasi are: lack of support from the FICI (the organization that support the creation of Jambi Huasi); changes on the board of directors of the FICI and permanent changes of rural doctors. Until June of 2008, eight rural doctors have worked in Jambi Huasi. “This is a big problem, beginning to convince them but even more to achieve that all doctors empathize with the patients. It is because of budget matters that we have not hired a person to work permanently (...). At the moment, we are in “stand by”. We require implementing new services, such as: 1) Labor room, 2) Chiromassages, 3) Research Center, to support the work of Jambi Huasi with academic researches and statistical basis”, Tamba added.

**Personnel selection of Jambi Huasi**

Currently, the team of Jambi Huasi is formed by 9 individuals, who have been recruited by this health center. They are: the executive director, Myriam Conejo (who currently conducts a research on tuberculosis in several provinces of Ecuador); the administrator, Jose Farinango (who is currently the director in charge in Jambi Huasi); a person in charge of information and payments, Darwin Tamba; a person in charge of the area of Pharmacy, Janeth Cando; a caretaker, Mary Carlosama, the accountant, Soraida Narvaez; and 3 Jambigkuna or people who know and practice traditional indigenous medicine (including a yachak, Javier Perugachi; a mamahua, “partera”, or midwife, Concepcion Brusil; and a jakug, Juana Perugachi).
In addition, beginning in 1997, the Ministry of Public Health is funding the annual work of a rural doctor in *Jambi Huasi*, which position is filled by a different person every year. Since 2001, this center also has the help of a professional obstetrician, through an agreement signed between *Jambi Huasi* and the School of Obstetrics of the Faculty of Medical Sciences, of the Central University of Ecuador.

So currently, the Ministry of Public Health is funding the salaries of the following biomedical professionals working in *Jambi Huasi*: 1 dentist, 2 doctors, 1 nurse, 1 psychologist (works temporarily, by appointment). The Central University of Ecuador also supports the work of the obstetrician in *Jambi Huasi*.

Authorities in *Jambi Huasi* have prioritized the following characteristics, to select the persons who work at this health center: (1) To be a bilingual person (who can speak Spanish and Kichwa). (2) To respect and value the contribution of traditional indigenous medicine. (3) To be ideologically and practically identified with the social work. (4) To agree with the proposal to meet the patient from a Bio - psycho – social approach. (5) To be committed to teamwork and trained for the activity for which she/he was summoned.

In the case of biomedicine, the authorities in *Jambi Huasi* chose to newly graduated students from the University, because they believed that young professionals were the people best suited to respond to the parameters that were considered for *Jambi Huasi*. "We believe that although they do not have previous experience over the academic training, they could ensure that their knowledge as well as their attitudes would be positive for a job that was intended to provide a friendly, open, humanitarian, and affectionate attitude and generating confidence, without discrimination". (Conejo et al. 2004: 17).

In the case of traditional indigenous medicine, health personnel is selected with the endorsement and support of indigenous organizations and the local FICI. The *yachak* Perugachi Javier, who is 53 years old and is working in *Jambi Huasi* for more than 12 years, had worked before with a famous *yachak* during 26 years.

The experience of the *mamahua* (midwife in English) and the *jakug* ("fregadora") comes from the learning that they received from their mothers and grandmothers during their adolescence and youth. Now the *mamahua* is 80 years and, the *jakug*, around 70 years old.

**Differences in payment**

Darwin Tamba, the person in charge of information and payments, said that a way to value the work of the professionals of both medicines is paying the same salary to the doctor and the *yachak*, and that midwives receive an amount equivalent to the people working in Obstetrics. But, through interviews and observation, I have been informed on differences in payments to members of *Jambi Huasi*’s staff.
With regard to salaries, Myriam Conejo explains: "by not having a benchmark to determine how we should pay to practitioners of traditional indigenous medicine, as an institutional policy we decided that they should earn an equivalent to what professionals of the Western system (biomedical) earn, consistent with the hierarchy of their colleague. For example, the yachak receives a salary equivalent to the salary of a biomedicine general practitioner, while the mamahua receives a salary similar to the obstetrician, and the jakug receives a salary similar to that of a physiotherapist (who works in the biomedicine system)". (Conejo et al. 2004: 18) She also explained that the Ministry of Public Health is responsible for paying the salaries of professionals in biomedicine, while Jambi Huasi is responsible for paying the jambigkunas.

Raul Mideros recalls that, during the research that he and other researchers conducted at the Jambi Huasi health center, in 1997-1998, he observed that most investment and economic expenditures that were made in this center were dedicated to purchase medicines and inputs from allopathic medicine or biomedicine. This aspect "reflected what was important for authorities of Jambi Huasi, because they spent more money in what they believed was a priority or a cornerstone of their proposed project", according to Mideros. He was surprised to know that there is much difference in the remuneration of people working in Jambi Huasi. For example, he recalls that the remuneration of the midwife was far below the remuneration of professionals in biomedicine. Such detail enabled him to realize that, in practice, there is a difference or inequity in the appreciation of people working in this health center.

This opinion was confirmed by the yachak of Jambi Huasi, Javier Perugachi, in an interview conducted during the process of fieldwork in this health center. According to him, in Jambi Huasi he receives USD 330 monthly, "but I earned more when I work at my own place. It is because of my love to the people and my appreciation to this organization that I keep on working for Jambi Huasi. I have to reduce my earnings to support this health center". Javier says that he currently attends only in Jambi Huasi as a matter of fact it is a hiring requirement not to work in other places. He affirms that Jambi Huasi receives around USD 1800 monthly by his services – as payment of the consultations, remedies or natural medicines prepared by him. He stands out that his salary is USD 330.

Maintaining the infrastructure and services of Jambi Huasi requires much funding, which now comes mainly from the payment of the patients for their consultations. "It requires about $60,000 (U.S. dollars) per year just to pay the salaries of 11 people", Myriam Conejo reported. She said that, from payment of consultations, lately Jambi Huasi collects $ 45,000 (U.S. dollars) per year, but she is seeking the support from other organizations or projects to finance the missing amount. Raul Mideros also believes that maintaining the infrastructure and staff working in Jambi Huasi implies a very high cost, which is a big problem for the administration of this health center.
Therefore, he recommends analysing what is the priority of *Jambi Huasi* now, in order to assess what are the goals that this center should prioritize in the future.

### 3.5. Meetings and collaboration

This section shows contrasting views on what is happening in spaces of work, in *Jambi Huasi*. The idea I had before starting my fieldwork in Ecuador has changed a bit at the end of this research. I thought that in *Jambi Huasi*, doctors and practitioners of traditional indigenous medicine had meetings to exchange views on their diagnosis. However, in practice, during my fieldwork I have observed that this exchange of views does not occur. Sometimes, the process of reference and counter-reference takes place, especially in the case of pregnant women who show signs of risk.

Javier Perugachi has worked as *yachak* in *Jambi Huasi* for more than 12 years. During our interview, he was hearing joyful music, instrumental, played by indigenous musicians. In his room there are two lit candles and the environment is cozy. During our conversation, he spoke slowly in Spanish, as if he were a wise counsellor.

He started the conversation with dynamism and with the following words: “I came to *Jambi Huasi* not to practice, but to teach people. I explain to my patients what the reality of the disease they have is, what the symptoms are and the limits of my healing. I inform them what kind of plants can cure their health problems, which my responsibility is. I never let the patients to continue consuming sedatives or tranquilizers, I try to offer them treatments which cure their health problems definitively”.49

When he was asked about his relation with other members of the staff at *Jambi Huasi*, including biomedical professionals, he affirmed that he has had a good relationship with everyone since they have understood and helped each other. To do it, he said that he has to have more understanding than others.

“I have to be more expert than anyone else. First, I have to respect them if I want to be able to approach them. That is why I have been able to learn to share other alternatives of health with other people. That is one of my characteristics; I am never against Western doctors (biomedicine professionals). I have had the good fortune or privilege to meet very good doctors and scientists, and I am happy to share with them my knowledge about plants. I have always said to my patients: ‘you must not be against Western medicine (biomedicine), you should approach it’. If Western doctors prescribe

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49 Javier Perugachi added that it has not always been possible to ensure the healing of a patient. "For example, I have just received a patient from Quito, who is at an advanced stage of cancer and who has been in treatment for 9 years. In that case, I can not offer him a cure. I prefer to inform on my diagnosis to a relative. If there are ways to cure it, I would do, but there are cases where it is impossible to do so (...). It is my responsibility to say this to relatives of patients", he said.
medicines, syrups, pills, I also prescribe it through natural and medicinal plants. If we combine the two medicines, it would be easier to cure" (Javier Perugachi, yachak of Jambi Huasi).

By the end of the interview, this yachak remarked that his wish is to teach his daughter Marina (who currently is 17 years old) his knowledge and practices as yachak, so she could also consider his expertise in the future, when she will be doing Medicine at the university. In order to show one of the materials that he will inherit to his daughter, he took out of the closet a big notebook where he has registered the data of his patients, year by year, day by day.

According to Myriam Conejo, the authorities of Jambi Huasi “have tried to boost the balance of both systems. This means that the staff does not feel jealousy on the provision of inputs and other requirements, because we have tried to offer fair treatment for both services”.

However, not all of the people interviewed had the same opinion when analysed the relationship that in practice the two systems have in Jambi Huasi. Such views have helped to answer the research questions that rose during the fieldwork; this section shows a detailed analysis on different opinions.

Vidal Sanchez, who introduced himself as herbalist and “fregador”, worked in Jambi Huasi for about two years; he resigned 8 years ago because, according to him, “leaders of Jambi Huasi could not achieve the objectives proposed by the center: combine western medicine (biomedicine) and traditional indigenous medicine (local knowledge). They preferred to support more professionals of western medicine (or biomedicine) and I did not agree”.

He thinks that, at the time he collaborated at Jambi Huasi, the leaders of the Center preferred the professionals in biomedicine, instead of supporting the labour of those working in traditional indigenous medicine.

“The leaders gave no facilities for people who worked in traditional indigenous medicine; we remained as the last priority, despite the fact that the greatest success of this center is due to the offering of services based on traditional knowledge. It has been always that way; the indigenous people have been considered the least. We have been more valued by international agencies, than by local authorities”. Vidal Sanchez expressed this view before trying to fix one of my toes, which I hit previously.

He added that, when he worked at Jambi Huasi, he had no medicines or support for prevention processes in the communities. “In addition, my salary was minimal. So, I looked for other options

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50 Currently Marina is doing the 4th high school year. Her goal is to study Medicine and become a surgeon, and to link the knowledge/practice of biomedicine with the knowledge/practice that she will inherit of his father.

51 In the notebook of this yachak, the information of each patient is registered as follows: date, name, last name, age, origin, diagnosis, and treatment.

52 Besides working as an herbalist, Vidal Sanchez is well-known in Otavalo as a good “fregador” (in practice, this work is similar to chiropractic or massage with hands).
and now I have my own consultation room in my own center, near the place where Jambi Huasi operates, and I am very well”, he affirmed.

About the treatments’ combining, Darwin Tamba (who works in this health center for more than 8 years), said that in Jambi Huasi, the biomedical doctors and indigenous medicine practitioners avoid combining treatments for the patients. “They can suggest to the patients to attend several doctors or medics, but they do recommend doing a treatment first, before beginning another”, he affirmed.

Therefore, in order to answer the empirical question: How far, in practice, does the dialogue of knowledge take place in Jambi Huasi? Or to determine if prejudices of any kind, concerning the biomedicine or traditional indigenous medicine, stand in the way, I would highlight the following reflection: in practice, the relation between biomedicine and traditional indigenous medicine exists in Jambi Huasi as a kind of game, where patients have the option to choose between different alternatives of health care. But, in practice, doctors (from biomedicine) and jambigkunas (people who know and practice traditional indigenous medicine) are not working together to create a new option of health care.

Making a simple comparison: it is like a center offering various fruit juices: orange, apple, pineapple or pear. Clients decide what kind of juice they want, but they rarely have the option of having a juice which is the combination of several fruits.

“And if they receive a juice of different fruits, it will always have the taste of one fruit, the one that prevails among the others that impose its characteristic colour or flavour. The same situation occurs with the attempt of combining biomedicine and traditional indigenous medicine”, Mideros added.

According to him, in the health field, he has realized that interculturalism may be the interstitial place where dominant and subordinate cultures exist. “The interculturalism is not submitted as a state or as something structured, but rather as a game, as a scenario in which the patient has the option to choose between several alternatives”, he said.

But, how are biomedicine and local knowledge deployed in the practice of primary health care, in the Jambi Huasi health center? In the opinion of Cesar Cotacachi (an indigenous man who is ecologist, photographer and a tourist guide in Otavalo), primary health care is "the first contact of the patient with a hospital, clinic or a health center of conventional medicine (biomedicine) or a center of traditional indigenous medicine, in order to receive the first diagnosis on their state of health". Based on this interpretation, he said that the primary health care offered by biomedicine would be equivalent to the diagnosis with "cuy" (also well known as guinea pig), or to the services provided by the yachak.
According to Myriam Conejo, director of the Jambi Huasi health center: "most indigenous people use the 'cuy' for two purposes: 1) to make diagnoses and 2) as a therapeutic method. But in Jambi Huasi the 'cuy' is used only to make diagnoses based on traditional indigenous medicine".53

Why is the "cuy" used in traditional indigenous medicine, for making diagnoses and therapies?

"Because the anatomic distribution of this animal is very similar to the human one. The 'cuy' is similar to a mouse in its anatomy; so, some researchers use mice to test medicines which, after that test, will be offered to humans. In Jambi Huasi, the jambigkunas could also use mice to diagnose the health problems of their patients; in Otavalo, it is easier to find 'cuy' at the home of the patients, because some people have this animal for food", the physician Conejo explained.

But Javier Perugachi, the yachak of Jambi Huasi, prefers to use other techniques to diagnose the health status of his patients. He prefers to observe "urine samples" or the candle's flame; taking the pulse (as the biomedical doctors usually do) and analysing the patient's breath.

In the first appointment, and with the purpose of diagnosing a patient's health condition, he asked for an urine sample – taken in the morning and in an appropriate cup, which is sold in drugstores or in Jambi Huasi. Then, he analyses the candle's flame to diagnose the "spiritual side of the patient".

He says that the candle's flame is like a TV screen to him, it is where he can see the health condition of the patient. "I do not ask the patients to tell me what it hurts them or what their problem is. I told them that this kind of information that can be given to a Western doctor (biomedical), but I am a wise man and I have to identify by myself the problem affecting their health".

In short, within the traditional indigenous medicine, one of the most important aspects is that the person who practised this knowledge has the respect and recognition of the community. The diagnosis can be made in different ways: through the flame, using the body of a "cuy" (guinea pig) or an egg, among other things. These diagnoses are usually associated with the healing process, whose rituals have to follow up some steps. People who practise these skills tend to choose the day, the place, even the hour for the consultation of patients, to make their diagnosis and treatment. "These people use different diagnosis tools and, in fact, their results are accurate" Matilde Farinango said, who also highlighted the efforts of Jambi Huasi, and other organizations, to achieve institutional recognition of the work of “parteras” (midwives), especially in Otavalo.

53 The diagnosis with "cuy" (guinea pig) is a technique sometimes used by the yachak or by other jambigkunas (indigenous medicine practitioners). The "cuy" is an animal that has a reverent place in the Andean culture. It is used as food as well as instrument to make diagnoses and for therapeutic process. The diagnoses or therapy with "cuy" involve that a living "cuy" is rubbed up and down on the legs and arms of patients, across their chest and shoulders and on the top of their head. Then, a yachak or jambigkuna tends to dissect the "cuy" (guinea pig), in order to provide a insight of the patient's health. Some yachak and other jambigkunas believe that the "cuy" is an animal that can absorb the negative energies of the patients. So, they think that when they use this animal in their diagnoses or therapies, the afflictions of patients are absorbed into the "cuy's" body.
The following section provides more detailed information on training and institutional support for midwives, as well as about the practice of the system of “Reference and counter-reference” between biomedical professionals and jambigkunas (people who know/practice based on traditional indigenous medicine).

3.6. Referrals: cases of Pregnancy and Childbirth

'I prefer to die in my house than go to the hospital'

"Until then, I had never seen a vertical childbirth, only in theory. But the pregnant woman told me she had received all their children through vertical childbirth. Suddenly, I heard the sound of the 'source of water' and I saw how the baby came down slowly from his mother, between her legs, as if he was on a slide. That was a beautiful image! What wisdom that woman had\textsuperscript{54}.

(Fragment from the interview conducted to Matilde Farinango).

The first initiative in the process of reference and counter-reference was proposed by the Ministry of Public Health, many years ago. “Because of the distance of indigenous communities from cities, the goal has been to operationalize the process of reference and counter-reference”, Matilde Farinango\textsuperscript{54} explained.

To clarify why she appreciates the work of midwives and the practice of vertical childbirth, she told me about an experience she had more than 10 years ago:

"I remember a year when, on June 24th, in an indigenous community a woman had to give birth; so their relatives were looking for the support of a midwife. My mother told them that I was a nurse and that perhaps I could help her. At that moment, I did not have the equipment to attend the patient. The pregnant women told me she preferred to die at home than to go to the hospital. I was afraid, because until then I had never attended patients outside the hospital, or without the support of a doctor. So I called to the hospital asking for an ambulance, in order to carry this woman to the hospital, but nobody responded to my call and, meanwhile, this woman already had birth pangs. Then I called the emergency number 911, and someone responded to my call; however, once that person asked me the names of the streets to send the ambulance and I had no such information - because the streets of that indigenous community had no names; we usually located houses for references. For that reason the ambulance took a long time to come; the pregnant woman had her childbirth contractions. To my surprise, without the help of anybody, the pregnant woman knelt and placed her body in a position that allowed her to receive the baby through childbirth in vertical position. Until then, I had never actually seen a vertical childbirth. But the pregnant woman told me she had received all their children through vertical childbirth. Suddenly, I heard that the 'source of water' sounded and I saw how the baby came down slowly from his mother, between her legs, as if he was on a slide. That was a beautiful image! What wisdom that woman had. I remember she told me: 'please, don't cut the umbilical cord yet, wait a moment'. I went to disinfect the material with which I could cut after the umbilical cord, while the bodies of the mother and her baby were still united. But at the end, was the mother who attended to her childbirth herself, because she knew how”. (Matilde Farinango)

\textsuperscript{54} Currently, she is technical of the National Direction of Health of Indigenous Peoples, at the Ministry of Public Health of Ecuador. Previously, she studied nursing at the Technical University of the North, in the city of Ibarra. The title of her Bachelor's thesis in nursing was: "Traditional medicine as an alternative healing", which she defended it in 1993, before going to work in the Jambi Mascaric center, in Cotacachi. For developing her thesis, she had the backing of the organization UNORCAC.
After the baby was born, paramedics and the ambulance of the 991 arrived at her house. The face of Matilde Farinango lights up with a smile of satisfaction, while she recounts this experience. “I remember it was a beautiful experience” she said, “I think it was really an intercultural experience”. In her opinion, it is not necessary that pregnant women go to the hospital to be cared for, but “doctors can also go to the houses of pregnant women for attending the childbirths there”. According to Farinango, this process could be considered intercultural because it allows doctors and patients’ interaction since their different world point of view and models of health care during childbirth.

“When the paramedics helped the patient to remove the placenta of her body, her other children knew what to do with this material: they had dug a hole near the hearth of the house, in order to bury the placenta inside, because that procedure is part of indigenous tradition, to avoid bad vices in the future of the newborn baby. In addition, the whole family could watch the childbirth process of the baby at home. I think these are the customs or traditions why most indigenous women, who are more accustomed to the procedure of vertical childbirth at home, don’t want to go to the hospital for the practice of childbirth”, Farinango opined.

Mercedes Muenala, who coordinates the area of Intercultural Health in the Provincial Health Direction of Imbabura for 7 years, is interested in the intercultural health services since 1989, when she did her rural service in an indigenous community of the Riobamba Canton, in the Cacha Health Center. In this community, she attended the childbirth of a woman (who was 28 year old), and “then I understood that many indigenous women do not want to have their babies in a hospital but at their home and with midwives”.

“I had studies on Western medicine (Biomedicine), but my grandmother was a midwife; that is why I had some knowledge that allowed me to attend that labor in the vertical way. Because, sometimes, indigenous people desire to know what kind of infusion they can drink to swallow the pills”, Muenala explained.

Job description of “parteras” (midwives)

During childbirth, the care of the “partera” (midwife) involves several actions, which depend on the needs of the pregnant mother and baby. At the time of birth, usually the "partera" uses the preparation of multiple infusions for which they use various plants, such as alfalfa flower, root of nettle, chamomile.

At the time of childbirth, it is important that the baby is placed in an upright position and with their heads down, because, otherwise the process of childbirth could complicate. In such cases, many midwives prefer to refer to the pregnant patient to the hospital.

55 She studied Nursing in the Technical University of the North, in Ibarra.
To make a vertical childbirth, the midwife chooses a warm location and transmits heat to pregnant women through the use of blankets, walking near the cooker and drinking hot tea.

With the “parteras” of Otavalo and of other Ecuadorian places, the position to be taken by the woman in labour is as follows: she must locate her body in a kneeling or squatting position; in addition she must support her arms over something that could sustain the weight of her body (may be a chair or a rope), and she also must open her legs. Then the midwife frictions the belly and waist of the mother, while her husband or any relative contend for her armpits.

When the baby is born, the midwife receives him/her, while the mother must try to forcefully expel the placenta of her body.

The care that women receive during vertical childbirth basically has a ritual function. The symbolism expressing these rites implies the need for women to have enough physical and spiritual strength for the childbirth, according to the midwives interviewed.

For this reason, “it is important to emphasize the social role that midwives have and all those involved in traditional medicine. Apart of the communitarian recognition they have, their profession is religious, not in a Christian sense, but in the sense that their ability to heal is the result of God's will, as mediators on the willingness of God. In the practices of midwives, we realized that they are working by exercising their willingness to serve” (Buitron et al. 2006: 69). The authors of this book argue that, from the point of view of modern medicine, the potential of the work of “parteras” (midwives) is immense, but many of their practices have not yet been well studied, and thus they are not well understood.

**Reasons for preferring the practice of vertical childbirth**

During a lecture given in the Cotacachi Hospital on May 28th, 2008, the Spanish physician Leandro Prieto explained some reasons why it is important to promote the vertical childbirth practice in Ecuador.

“According to the WHO, cesarean rates should not be higher to the 10% or 15% of the total labor amount. However, in Ecuador the cesarean rate is 40% and in private hospitals it could even reach the 60%. So, Ecuador is not accomplishing the WHO suggestions”, Prieto said.

According to him, the reasons of this high rate of cesarean in Ecuador are: patients’ disinformation, doctors’ rush to attend more patients or their will to earn more money for this kind of attention.

He values the vertical childbirth practice since he believes that it allow the baby to born in a more natural way, and because this practice “offers a better environment than in hospitals, which usually are very cold places, with inappropriate lighting”.

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56 More information about perceptions and arguments of indigenous women, explaining why they prefer the practice of vertical childbirth in their own communities, can be found in the Annex 6.4.
Prieto criticizes the fact that in many clinics and hospitals it is forbidden the access of the father or another relative during the childbirth. “The childbirth should take place in an intimate environment. It is a process involving two persons: the mother and the baby. So, we should respect how the mothers choose to have her baby (...). We should try that the labor be as natural as possible and the medical intervention, in complex cases, be as low as possible”, he said.

Considering the experience of the San Luis of Otavalo Hospital, the Public Health Ministry of Ecuador is considering the possibility of implementing this practice in other hospitals, nationwide. This proposal is justified on the idea that “there is a high mother-child death rate in Ecuador, especially in indigenous communities. That is why we should look for strategies that guarantee people’s health (...). The birth is not an illness”, Javier Teran said.

“I think it is important to conquer the space that was originally denied to us (...). If we are a multicultural and multiethnic country, if we have precious knowledge, why should not we take advantage of it? Why should not we take advantage of the Vertical Labor knowledge at hospitals?” Teran added. Based on his decision, the Vertical Childbirth Room of the San Luis of Otavalo Hospital was opened on April 4th, 2008.

**The process of reference and counter-reference**

Matilde Farinango recalls that at the time she began working on the Jambi Mascaric center, in Cotacachi, more than 10 years ago, the process of reference and counter-reference between midwives and the hospital had already taken place there. However, midwives felt that this process was inconvenient for them, “because they had to deliver information without receiving anything in return. Therefore, we had to promote the counter-reference from professionals of biomedicine to representatives of traditional medicine”.

Based on her experience, 4 years of work in the province of Pichincha, Matilde Farinango said that in this province midwives are delivering something like coupons (or vouchers) of reference and counter-reference. To develop the monitoring process, examination and evaluation with midwives, the authorities of this Ministry have asked the support of professionals of biomedicine, usually nurses. To accomplish the process, midwives send the patient with a reference coupon to the hospital, where they indicate that the patient is going to get pregnancy controls.

But, according to Farinango, sometimes there are problems, as when patients do not know which person in the hospital shall register the data of the reference coupons at the hospital, a necessary procedure in order to do the following and forwarding the data to the midwife, i.e. a report of contra-reference.

Another problem raises when biomedical doctors or indigenous medicine practitioners do not accept each others’ references of patients. “This is because there are some Western doctors (biomedicine) who do not accept the diagnoses made by people who practice traditional medicine,
and it also happens with some yachak who affirm they can cure any illness; so they prefer not to refer their patients to the hospitals", the physician Javier Teran said. However, he recalls that while he worked on Jambi Huasi (more than 4 years ago), he had a good relationship with the other team members, and that in several occasions he made references and counter-references with the herbalist Vidal Sanchez (who stopped working in the center 8 years ago).

This positive view of the reference and counter-reference practice in Jambi Huasi was confirmed by the psychologist Azalia Vasquez,\(^{57}\) who said: “The two health models are often complemented in Jambi Huasi. I believe that there is no discord between the two health models in the center, due to the fact that if a conventional medical professional (biomedical) realizes that a patient needs spiritual care, he or she recommends the patient to attend to the practitioners of traditional indigenous medicine". She said that sometimes patients come with physical problems at Jambi Huasi, and “if the doctor (trained in biomedicine) diagnoses that there are emotional reasons promoting the physical discomfort of his/her patient, then this doctor suggests the patient to consult to the yachak and vice versa”.

Nevertheless, Matilde Farinango has a different opinion: “about the process of reference and counter-reference, it has been said too much. In the practice the counter-reference rarely occurs”. She said that the practice of patients’ reference from traditional indigenous medicine to biomedicine is more common than the referral of biomedicine patients towards traditional indigenous medicine. Therefore, in her opinion, the process of reference and counter-reference between the biomedicine health service towards the traditional indigenous health service, and vice versa, would be possible only on the basis of trust, recognition and appreciation of the different types of knowledge.

**Different opinions related to the presence of midwives in hospitals**

At the end of May, 2008, during a lunch that took place after a workshop (whose subject concerned the implementation of the practice of vertical childbirth at hospitals) for doctors and midwives, I listened the opinion of a doctor who questioned the possibility of joint work with midwives at hospitals; he believed that the involvement of midwives could be a problem or an obstacle to his work and he does not want to take those risks with the patients under his responsibility.

When I asked him for an interview to talk about this issue, he confirmed me his opinion on that subject, but he also clarified that he agrees with the proposal of intercultural health, “this perspective is necessary, especially in communities with a high percentage of indigenous people”.

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\(^{57}\) She works for more than two years in Jambi Huasi. She began to work as a resident and now works part-time in this health center, where a patient asks for psychological aid.
This is the opinion of the physician Kleber Narvaez, who worked at the Asdrubal de la Torre Hospital, in Cotacachi.

Another physician who is against the presence of midwives at hospitals is Teresa Jaramillo, who was director of the Asdrubal de la Torre Hospital, in Cotacachi, until April 2008. She agrees with the training of midwives, so they can work in their respective communities and refer patients to hospitals when they show signs of danger or risk at pregnancy. But she disagrees with the participation or presence of midwives at hospitals.

By contrast, the 4th April, 2008, the San Luis of Otavalo Hospital inaugurated a Room of Vertical Childbirth and its director, Javier Teran, supports the presence of midwives if requested by the patient. To better explain his point of view, he mentions the alternative of childbirth assistance at home, which exists in the Netherlands.

“Childbirth assistance at home is an experience taking place in the Netherlands, they do have the necessary technical equipments and human resources to move a patient to the nearest hospital in case of an emergency – as labour complications. However, in Otavalo we do not have these conditions; there are long distance communities and we do not have enough ambulances or available doctors to move from one place to another. In order to avoid risks during pregnancy, we prefer to concentrate at the hospital the option of vertical childbirth and normal childbirth (horizontal), so the patient can choose and have the support of the necessary medical equipment”. This is an opinion of Javier Teran.

According to him: “it is important to keep our culture, to respect the beliefs and customs, even in the labour attention we provide. This is possible, to some women, through the practice of vertical childbirth”.

Due to the creation of the Vertical Childbirth Room in the San Luis of Otavalo Hospital, this canton has become a new. From April to June 2008, around 25 vertical childbirths were attended at the San Luis of Otavalo Hospital.

3.7. Recognition of indigenous medicine practitioners

Matilde Farinango said that Ecuador is making progress on implementing the process of vertical childbirth. Thanks to the support of several agencies, the National Direction of Health of Indigenous People (DNSPI, in Spanish) is developing the “Standard on Vertical Childbirth”, which will be ready on September, 2008; date when it will take place its official presentation in the city of Otavalo.

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58 Currently, he is coordinator of a sub-center of health in the indigenous community of Imantag, in the canton of Cotacachi.
59 She has worked at Cotacachi for 10 years and has been responsible for coordinating the development and implementation of the proposal on Intercultural Health in the canton of Cotacachi.
To analyse the certification process of the community midwives and their incorporation into the formal health system of Ecuador, a workshop at the San Luis of Otavalo Hospital was conducted from the 2nd to 4th July of 2008. This meeting was attended by technicians of the National Direction of Health of Indigenous People (such as Matilde Farinango), the National Health Council (CONASA, in Spanish), the Provincial Health Direction of Imbabura as well as of other organizations.

By the end of July of 2008, another meeting was convened in order to finalize the analysis of the recognition and procedures related to the midwives’ communitarian endorsement. In these workshops, the work of midwives and the influence of cultural patterns in the health care of indigenous and “mestizo” people is taken into account.

**Code of ethics and labour analysis of the yachak**

According to the director of Jambi Huasi, Myriam Conejo, there is a weakness in the Intercultural Health Area of the Provincial Health Direction of Imbabura: “it has not identified and has not given the accreditation to the authentic yachak”.

In 1999, the Constitution of Ecuador approved the exercise of the traditional indigenous medicine. “But as a previous step, they should have done a registration and have given an accreditation to the persons who are authentic representatives of this knowledge and practice. Since there was no register, some people who do not know about the subject are cheating several patients. Those fake promoters of the traditional indigenous medicine have discredited to those who really know about this practice”, Myriam Conejo commented.

In her opinion, sometimes it is counterproductive to promote traditional indigenous medicine because many people who do not know about the subject are taking advantage of some patients’ naivety and of tourists. “The Provincial Health Direction has not done anything to avoid these boasters to practice the traditional indigenous medicine”.

But Matilde Farinango explained that, in addition to the acknowledge and analyse of the midwives’ work (to assess their knowledge and practices within the National Health System of Ecuador), the National Direction of Health of Indigenous People also develops activities and designed projects to analyse the situation of the group of yachak, “fregadores”, jakug, mamahua, and other representatives of traditional indigenous medicine.

“The matter is not about including them; it is about their participation more like as a contribution to health than as a complement. Some provinces do not agree that the group of yachak can be considered within the health services, as they believe that this would run counter to their own knowledge”, Matilde Farinango said.
She explained that the main opposition to the inclusion of *yachak* in the official health system of Ecuador is “because some elderly say that the work of *yachak* at hospitals would not be a consistent procedure with the wisdom of these people”, so this, it is an issue still under discussion.

She hoped that it would be possible to move on that analysis once the code of ethics, concerning the practice of traditional indigenous medicine, is ready. To analyse this situation, the National Health Direction of Indigenous People, other organizations and health institutions will develop three regional workshops, in August of 2008, with the aim of drawing up the Code of Ethics related to the work of *yachak* and other connoisseurs of traditional indigenous medicine. The final documents of this Code of ethics will be ready on September, 2008.
4. CONCLUSIONS OF THE THESIS

Unsatisfied social needs, aspirations and daily conflicts – but mainly life conditions and the increasing poverty – have been key factors for social mobilization and the organization of Kichwa indigenous people of Otavalo, Ecuador. These were also causes for the foundation of Jambi Huasi, by the Indigenous and Peasant Federation of Imbabura (FICI, in Spanish), in 1983.

In the context of Andean countries, such as Ecuador, medical pluralism has been a topic well documented and frequently discussed in anthropological literature, as has been detailed in Chapter 2. In the light of this literature, to develop this research the Critical Medical Anthropology has been selected, because this approach understands health issues in the context of encompassing political and economic forces that pattern human relationships, shape social behaviours, condition collective experiences, re-order local ecologies, and situate cultural meanings, including forces of institutional, national and global scale. The Critical Medical Anthropology recognizes that patterns of medical pluralism tend to reflect hierarchical relations in the larger society.

This research also has combined a political economic perspective with a symbolic approach. Because the meaning of traditional indigenous medicine, as well as any medical alternative, cannot be viewed apart from the socioeconomic and political realities of the everyday life.

During the fieldwork that supports this research, I was able to realize that there are clear differences of opinion regarding the way in which the biomedicine and traditional indigenous medicine are related. Some interviewed people see collaboration; others, a process of subordination or incorporation of traditional indigenous medicine into a hegemonic biomedical system. Then, in order to explain my conclusions, I will start contrasting views of what is going on in Jambi Huasi (in Otavalo, Ecuador).

In all the conducted interviews in this health center, from May 26th to July 6th of 2008, both with its staff as well as with patients, the stressed idea is that in Jambi Huasi the knowledge/practices of biomedicine and traditional indigenous medicine exist alongside one to another and that they are alternately or even concurrently utilized by indigenous and “mestizo” people.

Leaders of the staff of Jambi Huasi believe that the differences between biomedicine and the traditional indigenous medicine should be overcome; some even believe that the creation of this health center is already helping to overcome the problems of understanding between doctors and jambigkunas (people who know and practicing traditional indigenous medicine).

But, in practice, the dialogue of knowledge between biomedicine and traditional indigenous medicine is very limited within the Jambi Huasi. This idea is confirmed by the researcher Raul
Mideros, who thinks that in *Jambi Huasi* the prejudices have been insurmountable and even necessary when it comes to defend the validity of each one. In his view, in *Jambi Huasi* the road is littered with good intentions and many obstacles; one being the language.

All doctors and *jambigunus* (yachak, "parteras" or mamahuas, jakug, and "fregador"), who were interviewed during the fieldwork agree with the proposal of intercultural health. But some of them questioned the presence of representatives of biomedicine and traditional indigenous medicine in the same area; for example, into hospitals or health centers.

The process of "Reference and counter-reference" is one of the practices that has been promoted by the *Jambi Huasi* health center to consolidate the relationship of dialogue, mutual respect and appreciation between biomedical professionals and *jambigunus*, or representatives of traditional indigenous medicine. In practice, this process has been more efficient in the practice of vertical childbirth, which has had much support in Otavalo.

On April 4th of 2008, a "Vertical Childbirth Room" was opened at the San Luis of Otavalo Hospital. After that experience, technicians of the Ministry of Public Health of Ecuador, of the National Health Council (CONASA, acronym in Spanish) and more health agencies, are working together to develop the "National Standard on Vertical Childbirth". The official presentation of this Standard would be in September of 2008.

Despite those proposals, the majority of the persons interviewed during the fieldwork were concerned with the lack of criteria related to the evaluation and accreditation of the work of people who practice traditional indigenous medicine. Due to the lack of such criteria, they believe that now several charlatans are offering services under the slogan of traditional indigenous medicine, which is discrediting it.

To overcome this problem, the Ministry of Public Health of Ecuador is organizing workshops and meetings to promote the development of a "Code of Ethics"; with the aim to analyse, evaluate and regulate the work of people engaged in traditional indigenous medicine. These workshops are taking place in several provinces of Ecuador, especially in Otavalo.

Different techniques of diagnosis and treatment of the traditional indigenous medicine that are practiced in *Jambi Huasi* could be part of the Andean Amazon medicine.

Although there are several classificatory schemes devised by anthropologists, recognizing the diversity of medical systems in complex societies (which is detailed in Chapter 2), traditional indigenous medicine that is practiced at the *Jambi Huasi* health center is not yet recognized as a Complex Medical System (according to the criteria proposed by Madei T. Luz).

But a group of researchers of the Andean University Simon Bolivar, Ecuador, as well as of other research institutions of Latin America, are analysing the possibility of recognizing traditional indigenous medicine as a Complex Medical System.
In Ecuador, more than 10 years ago, the Public Health Ministry began a process to recognize and promote the incorporation of indigenous perspectives, medicines and therapies in national health programmes. For this reason, in 1999 the Public Health Ministry of Ecuador created the National Health Direction of Indigenous People.

The knowledge and practices of traditional indigenous medicine have also been incorporated into the reforms to health code, as well as the intercultural focus in the articles of the law of the CONASA.

As elsewhere, in Ecuador the biomedicine had had higher prestige than the traditional indigenous medicine in the context of white people and "mestizos", while the traditional indigenous medicine had been especially preferred by indigenous people.

However, this preference has changed over time. Now, Jambi Huasi receives more indigenous patients asking for health care based on biomedicine, while increasing numbers of "mestizos" are more interested in the services based on traditional indigenous medicine.

I think that traditional indigenous medicine has gained popularity also among "mestizo" people because it is less expensive than biomedical treatments, its use permits greater patient participation than in biomedicine, and because it embodies, in some way, important ideologies on cultural diversity of Ecuador.

To understand the cause of this preference, it is important to consider that the selection of a particular medical system could be interpreted as a critical domain to our sense of selves, infused with enormous power and riddled with different paths that access material and nonmaterial wealth. Libbet Crandon-Malamud analysed this idea based on her research in Bolivia. In Otavalo, Ecuador, resort to various medical alternatives may reflect reality, but they also could reinforce Crandon-Malamud's main conclusion that a cure is only one of many goals or outcomes of medical choice.

At the level of the patient-practitioner relationship, empathy developed from a profound concern with the exigencies of daily life marks the efficacious of the encounter with traditional indigenous medicine.

Based on my observations and interviews, I think that the staffs of Jambi Huasi are courteous, usually kind, and they do not treat their customers as they were second-class citizens. However, a big problem of biomedicine in Ecuador has been the attitude or the way in which many doctors usually attend to indigenous patients in hospitals, clinic or health centers.

The demand of indigenous populations to get access to health services is not just a matter of expanding the health coverage, but also of improving the quality of services, good treatment and respect to their culture. For them, the concept of health is not only the absence of pain and illness; it presupposes the existence of a good relationship with the family, community and nature. In
other words, for Kichwa indigenous people of Otavalo, to be in good health mean experiencing the *Sumak Kausay* (Kichwa word that means “best life”, in English). The understanding and respect for this vision is one of the main characteristics of the traditional indigenous medicine.

Most people interviewed in *Jambi Huasi* believe the interculturalism in health suggests the search of the *Sumak Kausay* of patients from the support of both health systems: from biomedicine and traditional indigenous medicine.

To analyse the subject of intercultural health, in this research the definition by A.M. Oyarce has been considered. She understood the interculturalism in health as the ability to move between knowledge, different cultural beliefs and practices regarding health and disease, life and death, the biological, social and relational body.

In multi-ethnic and multicultural countries, such as in Ecuador, intercultural medicine is an ongoing process of transactions, which gives an enormous amount of changes, adjustments and exchanges at a technical, theoretical and ideological level.

Most interviewed people during the fieldwork used the concept of intercultural health in order to relate to the parallel way in which the different knowledge/practices of biomedicine and traditional indigenous medicine are offered, in the *Jambi Huasi* health center.

In the light of the data analysis, from the fieldwork and the reviewed literature, I thought it would be necessary to reformulate the main research question, as follows: How does the concept of "intercultural health" allow understanding the way in which different knowledge/practices of biomedicine and traditional indigenous medicine are related in the *Jambi Huasi* health center?

Based on the analysis that will be generated with the answer to this question, another question would be: Has the relation between biomedicine and traditional indigenous medicine become hybridized in the practice of health care provided by the *Jambi Huasi* health center?

To answer these questions, it is necessary to refer the analysis presented in the Chapter 2. In short, in that Chapter it is explained that the hybrid shall be conceived as a product of power relations that do not disappear in the mix but are kept and reproduced. The hybrid in different medical systems is expressed in the articulation and mixtures of the imaginaries that define every form of knowledge and medical practice. So, the concept of "hybrid cultural" is situated between two poles and, in the case of *Jambi Huasi*, it is situated between biomedicine and traditional indigenous medicine. The fact to deny those both poles has created the possibility to claim the knowledge of people which is subjected to the domination of the cosmopolitan society and culture.

This is exactly what can be observed in *Jambi Huasi*. In practice, the relation between knowledge and practices of biomedicine and traditional indigenous medicine in this health center is showing hybridization. This trend has been confirmed during the fieldwork.
Hence, in the Jambi Huasi health center, the relationship between biomedicine and local knowledge (traditional indigenous medicine), in primary health care, has been reproducing the power of the biomedicine; in the practice, the "modern" or "biomedical" framework of meaning has become more significant than the local one.

The use of the term “hybridization” is based especially on the analysis developed by the Mexican anthropologist Steffan Ayora in his ethnography entitled *Globalization, knowledge and power: local medicine practitioners and their struggles for recognition in Chiapas*.

About “intercultural health”, the epidemiologist Jaime Breilh considered a big problem if this concept would be limited only to refer to curative aspects of medical systems.

In analysing the relationship between biomedicine and traditional indigenous medicine, Breilh has clarified that he prefers to talk about horizontality in relationships, so he prefers using the term "intercultural construction of knowledge", based on analysis that promote the unification of two approaches: 1) critical thinking in social science —anthropology, economics, sociology and social sciences applied to health—, and 2) indigenous critical thinking.

Raul Mideros affirms that sometimes the use of the term intercultural health remains the letterhead of subordination to biomedicine’s practices or strategies. Therefore, he does not believe that interculturalism in health was possible, if there is not a real recognition of the diverse knowledge and practices in health, based on biomedicine and traditional indigenous medicine.

In the health field, he believes that the interculturalism is not a model, but it may be the 'interstitio' where the dominant culture and the subordinate culture are present. Because, in his view, the interculturalism is not submitted as a state or as something structured, but rather as a game, as a scenario in which the patient has the option to choose between several alternatives.

This view applies to the case of Jambi Huasi: the staff of this health center is not working to create together, as a team, a new option of health care; but to offer different alternatives of health care in the same place.

All doctors and jambigkunas who were interviewed during the fieldwork agree with the proposal of intercultural health. But some of them questioned the presence of representatives of the biomedicine and traditional indigenous medicine in the same area; for example, in hospitals or health centers.

The idea I had before starting my fieldwork in Ecuador has changed a bit at the end of this research. I thought that in Jambi Huasi doctors and practitioners of traditional indigenous medicine had meetings to exchange views on their diagnosis. However, in the practice, during my fieldwork, I have observed that this exchange of views does not occur.

Sometimes, the process of reference and counter-reference takes place, especially in the case of pregnant women who show signs of risk. Nor has been a systematization of experiences, due to
the change of biomedical professionals which occurs yearly, especially general physicians, who are usually professionals that conduct their rural work service in Jambi Huasi, but only for one year. Therefore, almost every year has been like an adventure in Jambi Huasi, as a new experience, trying to involve the biomedical professionals in the process of combining medical systems, to achieve what Javier Teran called the 'transfer of knowledge'. Nevertheless, it seems that the transmission of knowledge remains unidirectional in Jambi Huasi.

When the speech of a doctor is not connected with the speech expected by a patient (because doctors and patients do not communicate among themselves in the same language, or by difficulties of a doctor who cannot explain a diagnosis or treatment to a patient), sometimes conflicts and dissonances arise.

This is one of the main reasons why, for many centuries, some indigenous people have preferred to seek health care services with people of their own culture, and based on the traditional indigenous medicine.

If the dialogue between people of different cultures becomes intercultural, then the traditional unidirectional model of the communication of biomedicine will have to be reformulated, from socio-cultural and intercultural perspectives, to become a more complete model of communication. So, the new model of communication should take into account the connections between forms of organization of the society (the politics-cultural), socio-economic mediations, and cultural characteristics of actors.

Hence, based on data collected from interviews, observation, and literature review during the fieldwork, I can highlight the need to implement a model of intercultural communication, to promote a best relation between knowledge and practices by doctors and jambigkunas, in the Jambi Huasi health center.

It could be very revealing to analyse in Jambi Huasi how the dynamics of metropolization of the city of Otavalo may be a reference to illustrate how a health care service shows crucial aspects of the Kichwa culture, where the boundary between the folklore and ancestral aspects is unknown.

Therefore, if we analyse the practice of reproduction of ancestral aspects in Otavalo and, particularly, in that health center, an interesting research question would be: where is the limit between the reproduction of the ancestral and folklore aspects, reproduced for commercial purposes?

To answer this question, the researcher Raul Mideros has proposed to analyse in depth how, in the Kichwa culture of Otavalo, the production and handicrafts trade allow to understand, in parallel, the characteristics of production and trade of symbols and tangible or intangible products; a particularly case study could be the Jambi Huasi health center.
Understanding this context would allow us to comprehend the real characteristics of the relation between biomedicine and local knowledge in Jambi Huasi, to know what type of project is being developed in this health center, or to reveal what is the background of these relations in practice.

It would be important to consider in future researches the analysis or the redefinition of the term "indigenous", as well as the influence of several organizations in designing and implementing health projects, which could be examined through an analysis of the so-called "indigenous knowledge".

Finally, through the analysis proposed about the concept of "hybridization" and "intercultural health", I believe it is necessary to change the conception of intercultural relations.

Until now, the rhetoric on multiculturalism remains dominated by the idea of tolerance, which implies inequality, because it assumes that one part has the power to "tolerate" the other.

This research proposes to go beyond tolerance, when analysing the relationship between biomedicine and local knowledge. Instead of tolerance, the proposal would be to promote the acceptance and respect from each to other cultural forms. It is only through this acceptance, validity and a not changing recognition of medical knowledge and cultural otherness, that it will be possible to foment an "intercultural construction of knowledge".
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Young, James Clay, and Linda Garro

6. ANNEXES

ANNEX 6.1. Glossary

* In this thesis, words written in Kichwa are in Italics; and words written in Spanish are in quotes.

Local Knowledge:

In this research, the local knowledge which has been analysed is the so-called traditional indigenous medicine. In this context, health and illness are associated with religious, magical and empirical elements; hence, medical practice is also related to the practice of rituals, rules and representations. Traditional indigenous medicine is a kind of knowledge, passed down from generation to generation, based on experience and observation of nature. In Ecuador, especially in Kichwa indigenous communities, the indigenous knowledge is interpreted as a wealth of knowledge about plants, animals and other natural phenomena; which would be result of the permanent relation between human beings and nature.

Traditional Indigenous Medicine (TIM):

This term was preferred in this research because it is the most used by people interviewed during the fieldwork. An even more accurate term might be: “Kichwa Traditional Indigenous Medicine of Otavalo”, but in this research a shortened version was written. The term Traditional Indigenous Medicine has also been used in the reforms of Health Code of Ecuador, when the incorporation of knowledge and practices of Indigenous Traditional Medicine was proposed.

Sumak Kausay:

Indigenous health systems of healing are based on a holistic concept of health. According to this concept, the welfare is interpreted as the harmony between individuals, communities and the universe that surrounds them. Therefore, human beings, nature and the collective history of the ancestors are united in an indivisible form and the illness is both, a phenomenon of the soul as well as of the body. So, from this perspective, health also depends on adherence to social norms and compliance with the moral obligations. When these norms are not met, there may be disease. (Alderete 2004: 71) In indigenous communities of the Imbabura province, and in other provinces of Ecuador, this holistic concept of health is well-known as Sumak Kausay. The meaning of this Kichwa term would be “Best life” in English. From the perspective of the traditional indigenous medicine, the interculturalism in health suggests the promotion of the Sumak Kausay of patients from different medical alternatives. In the case of the Jambi Huasi health center, this promotion is based both on biomedicine as well as on traditional indigenous medicine. The director of the Health Area at the Andean University Simon Bolivar, Jaime Breilh, also prefer to understand the

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60 He integrates international agencies and is one of the founders of the so-called "Critical Epidemiology", through which he defends the importance to find a vision in health above the curative level. In his books, such as: Critical
health as an entirety, because, in his view, “health is the entire set of processes that lead to good or bad living”. That is another idea people working on the critical thinking in social science—anthropology, economics, sociology and social sciences applied to health—, and indigenous critical thinking agree with. According to Breilh, the concept of Sumak Kausay would be interpreted as “healthy lifestyle”.

**Intercultural construction of knowledge:**

Taking into account the analysis concerning Sumak Kausay, Jaime Breilh proposes the “intercultural construction of knowledge”, for linking the critical thinking of social science and the critical thinking formulated by indigenous people, to jointly analyse the existing social system, “to which we have to criticize for not being fair, because it reproduces great social discrimination”, Breilh believes.

However, although he warns that there is still much work to do in order to achieve the construction of intercultural knowledge, he trusts in the fact that social sciences are opening to the possibility of another kind of knowledge. Breilh stressed that it is only recent, since the end of the previous century and the beginning of this one, when emerged an epistemic phenomenon that began to recognize that science is not just what scientists think.

Although Breilh has been formed in exact sciences, such as mathematics, he is concerned about analysing and writing books that relate to the need to build a science that assumes knowledge of the others as a valid knowledge, “and not just as a folkloric or sympathetic fact”, he said.

If one accepts the proposal to construct the interculturalism from a horizontal relationship (for example, between biomedicine and traditional indigenous medicine), then it would be necessary to know how to combine the both for discussing any problem. This would be a great challenge, according to Breilh: “How to construct interculturalism formed by the vision of all critical voices, so that we can discuss together any phenomenon?”

Establishing this kind of interculturalism “implies much more than the practice of vertical childbirth, herbal, the psychotherapy of a yachak, or any kind of healing”, according to Breilh, who added: “I do not even need that some people tell me: ‘we will distribute vaccines to all poor children in Ecuador’. Because in this way they can only postpone the morbidity for later. And about what sustainability does it give to the life of these children? Hence, we must be more critical about the system”. Due to think in that way, Breilh thinks that some people would describe him as radical. “But philosophically and ethically, from any standpoint, it is necessary to be more critical. What in essence justifies this proposal is the yearning for a more rational world, less idiotic”, Breilh affirmed.

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Epidemiology: intercultural science and emancipation (in Spanish: Epidemiología crítica: ciencia intercultural y emancipación), he analyses how studies on health, especially epidemiology, are a transfiguration of power relations.
Hybridization:

In this research, hybrid has been conceived as a product of power relations that do not disappear in the mix but are kept and reproduced. The hybrid in different medical systems is expressed in the articulation and mixtures of the imaginaries that define every form of knowledge and medical practice. So, according to the anthropologist Steffan Ayora (2002:57), the concept of “hybrid cultural” is a result of the combination of local/regional/cosmopolitan knowledge and practice. In his view, different kinds of complex knowledge and practices (such as biomedicine and traditional indigenous medicine) are already hybrids - since its starting point - and each seeks to legitimize itself through a rhetoric based on authenticity, originality and purity.

By considering this analysis, the relationship between biomedicine and traditional indigenous medicine can finally reproduce the power of the biomedicine, if a “modern” and “global” framework of meaning becomes more significant than the local one. This trend has been confirmed in the current case study, during the fieldwork at the Jambi Huasi health center.

Illness and treatments based on Traditional Indigenous Medicine (TIM)

Cleaning with egg (“Limpia con huevo”, in Spanish): In Jambi Huasi, it is a technique based on TIM used to diagnose a kind of illness or suffering.

Cleaning of bad air (“Limpia de mal aire”, in Spanish): In Jambi Huasi, it is a treatment based on TIM that is used to overcome a kind of illness or suffering.

Cleaning with “cuy” or guinea pig (“Limpia con cuy”, in Spanish): In Jambi Huasi, it is a technique based on TIM used to diagnose a kind of illness or suffering.

“Encaderar”: action after childbirth, to return the uterus to its place.

“Espanto”: shock caused by any situation in the countryside.

“Susto” or “espanto”: “Susto” illness indicates that the illness lies in the supernatural domain and hence in the world of the “curandero”, shaman, “yatiri”, and home care; and not in the world of physicians, drugs, money exchange, clinics, and hospitals. (Crandon-Malamud 1983: 164).

People who provide health care in Jambi Huasi based on TIM

“Fregador”: herbalist/massager.

Jakug: Person who provides diagnostics and treatments based on traditional indigenous medicine. Usually, she offers diagnostics with “cuy”, in addition to practicing clean of “mal aire”.

Jambigkuna: in Jambi Huasi, this is the used name to refer, in general for people who provide health services based on traditional indigenous medicine. So, this name refers to: yachak, “partera” (or mamahua), jakug, herbalist and “fregador”.

Mamahua: This Kichwa word is used by the staff of the Jambi Huasi health center to refer to “partera”, in Spanish, or “midwife” in English.
Yachak: Spiritual healer. The *yachak* is the *jambigkuna* who receive more patients per day in the *Jambi Huasi* health center. Within Kichwa indigenous communities of the Imbabura province, the yachak is well appreciated as a wise man/woman.

*Other Kichwa words or expressions*

**Kamari:** This word means “reciprocity” in Kichwa.

**Ranti ranti:** This term means to give and to receive, in Kichwa.

**Runa Shimi or Kichwa:** This language is result of a fusion between the Quechua language brought to the region by the Incas from Peru and indigenous pre-Kichwa languages.

**Conceptual approach**

The conceptual approach presented below is based on pre-existing literature, as well as on experiences about the implementation of the program “Health of the Indigenous Peoples of the Americas”, by the Pan American Health Organization (PAHO), and Member States of this Organization (PAHO 2008: 7-13, 160-165).

Another publication of PAHO (2002: 11-12) used the term “harmonization” as a synonym for conciliation, consensus-building, or mediation, and the term “incorporation” as a synonym for association, inclusion, or access (Ortega-Cavero 1991). However, the use of other words to represent the need for collaboration between indigenous health systems and the conventional health system is recognized, making it important to notice that a number of these terms may have meanings associated with socio-cultural contexts. For example, the word integration as a synonym and euphemism for assimilation is associated with the 1940s trend toward the implementation of policies to improve the living conditions of indigenous populations mainly by assimilating or “integrating” them into the so-called “national society” (Stavenhagen 1992:8). The following table presents some of the terms used in different publications on the subject in question. Several synonyms are included.

<table>
<thead>
<tr>
<th>Terms utilized</th>
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<tr>
<td><strong>Incorporation</strong></td>
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<td><strong>Integration</strong></td>
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<td><strong>Collaboration</strong></td>
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<td><strong>Articulation</strong></td>
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<tr>
<td><strong>Harmonization</strong></td>
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<td><strong>Complementarity</strong></td>
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Source: (Ortega-Cavero 1991)

In this research the analysis of the term “hybridization” has been preferred.

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61 According to a report of the PAHO (2002), although the description of the term complementarity has a sense of subordination, several researchers speak about the principle of complementarity when describing the philosophy of the Andean indigenous peoples. (Yanez del Pozo et al. 2002: 129).
ANNEX 6.2. Changes of the Case Study on the research proposal

Based on the information obtained so far, I have suggested changing the title of my previous research proposal. Instead of the title: “The ‘harmonization’ of biomedicine and local knowledge in primary health care: Experiences and strategies of the Jambi Huasi health clinic, and the Jambi Mascaric health center, in the Imbabura province of Ecuador”, I have suggested to use the following title: "The relation of biomedicine and local knowledge in primary health care: Experiences and strategies of the Jambi Huasi health center in the city of Otavalo, in the Imbabura province, in northern Ecuador".

So, instead of the term "harmonisation", I proposed this research focus around the term "relation", because there are a lot of interpretations on the term "harmonisation" and the diversity of views does not allow me to concentrate my fieldwork on the research questions, such as: Has the distinction between biomedical knowledge/practices and local knowledge/practices lost its relevance or do these two ways of knowing conflict with each other in the primary health care provided at Jambi Huasi?

Criticisms about the use of the term harmonization

Regarding to the use of the term "harmonization" in health topics, by PAHO or other international organizations, Raul Mideros believes that some organizations “have created another parallel market of ideas, a market of words, a market of jargon, a market of harmonization, and a market of fiction. Because, to some extent, these organizations have helped to create a simulation of ancestral aspects, but using many practices of biomedicine”.

"How barbarian, until the 'new age' reaches PAHO, because harmonization has much to do with waves of the new era", Mideros joked when I asked him about the use of the term "harmonization".

To explain his point of view, he made the following question: How many things, what many people call 'holistic', really are not ancestral in Andean practices?

He believes that many Andean practices are not holistic, because they don't have a vision of harmonization, or because they aren't characterized by balance.

In his view, the idea of balance is to some extent "a cliché that wants to force conditions, prospects and ways of how medicine is tended to be practised, and some of the recommendations or approaches that underpin these medical cultures". Therefore, Mideros believes that the term

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62 At the beginning, in the research proposal, I used the term harmonization as a synonym for conciliation, consensus-building, or mediation. But, during the fieldwork I preferred not to focus the research questions in this concept and, instead, I chose to talk about the relationship between of biomedicine and local knowledge in primary health care.

63 In this research, the so-called local knowledge is based on the traditional indigenous medicine.
harmonization promotes the idea that there is something holistic. "But, from my point of view, they are different things. One thing is the holistic and another thing is an entire ancient thought", he said.

Another critical opinion on the use of the term "harmonization", talking on the relation between biomedicine and traditional indigenous medicine, was expressed by the director of the Health Area at the Andean University Simon Bolivar of Ecuador, Jaime Breilh, in the following words: “if the harmonization implies the merger between unequal, this merger will mean the defeat of the weakest and, in the case of health, it means that in such merger tends to predominate biomedicine”. In other words, Breilh said it is not possible to talk of a merger between knowledge/practices based on biomedicine and traditional indigenous medicine, if those systems are not equal.

To avoid criticisms such as those mentioned above, for more than 4 years ago the PAHO preferred to discard the use of the term "harmonization" in their projects concerning “Health of the Indigenous Peoples of the Americas” (PAHO 2008).

For this reason, despite the fact that in the title of the research proposal of this thesis was included the term “harmonization”, its use was discarded during the fieldwork in Ecuador. Instead of that word was preferred to use the term “relation”, to focus the analysis only on the research questions.

Why it is not included Jambi Mascaric of Cotacachi in this research?

After one week of the fieldwork period in Ecuador and once I was able to know better the two centers that I had considered for my research proposal, I decided to focus my fieldwork only in the Jambi Huasi health center, which is located in Otavalo, and not to continue the research in Jambi Mascaric, which is set in Cotacachi.64

The decision was based on the fact that currently this center is operating as a training center more than as a health center, in the city of Cotacachi. Most of its health services are provided in remote rural communities and are only based on traditional indigenous medicine, not taking in consideration the biomedicine knowledge/practice. So this, the particular characteristics of the center could not give data to respond the my research questions.

Years ago this center received the support of different organizations - public and private, national and international (such as the “Doctors without Borders”) - to develop health programs or to provide training in health issues. Generally, these programs were led by medical professionals,

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64 Cotacachi is the largest canton in the Imbabura province. Cotacachi’s population is of about 7,000 inhabitants; indigenous people were estimated at 37.29%, according to the latest Census 2001. This town is located about 65 kilometres north Quito (Municipality of Cotacachi 2005: 5).
and supported by people working on traditional indigenous medicine. But, at present, in the center staff is composed only by mamahuas (midwives), who had been trained for working as health promoters in their own communities. When they observe risk signs in the pregnancy, they refer the patient to the hospital.

According to Teresa Jaramillo, who was the director of the Cantonal Health System of Cotacachi until April 2008, Jambi Mascaric is not a health care center or a health care service, "because it only offers services of the ancestral medicine". In her opinion, Jambi Mascaric is the Cantonal Direction or the Cantonal Office of Ancestral Medicine in Cotacachi.

Currently, Jambi Mascaric operates as a program of the Union of Indigenous Peasants Organizations of Cotacachi (UNORCAC, in Spanish), which is supported by 43 communities of the Cotacachi canton. Before Jambi Mascaric had more power within UNORCAC, it was the health area of this organization; but it lost power due to differences or political aspirations of UNORCAC's leaders.

**Political influence in health in Otavalo and Cotacachi**

By the end of 2008, the mayors' national election in Ecuador will be held, and the current mayors of Otavalo and Cotacachi want to be re-elected. Both are indigenous and are recognized in Ecuador as powerful indigenous leaders. They have promoted the organization of indigenous movements and programs in the Andean region of Ecuador, from 1990 onwards.

In the canton of Cotacachi, Auki Tituaña has been the mayor for the last 12 years, and he wants to win a new election as prefect (provincial governor) of the Imbabura province, at the end of 2008. The promotion of intercultural programs in health has been one of his main political strategies in Cotacachi. While in the canton of Otavalo, Mario Conejo has been the mayor for 8 years, and he wants to be re-elected as mayor of this canton. Although he also promotes the proposal of intercultural health, he prefers to avoid any political influence in the official health system of Otavalo.

About the Jambi Huasi center, he said: "In this health center, patients have the chance to decide the kind of medicine they want: services from Western medicine (biomedicine) or from traditional indigenous medicine. Besides there is a promotion of referral practices".

Sometimes, Mario Conejo supports programs of health, but he does not have problems in his relation with Jambi Huasi. Instead the mayor of Cotacachi, Auki Tituaña, has problems in his relation with leaders of the organization UNORCAC and the Jambi Mascaric center, due to political differences or due to political strategies of power. So that, if I would have decided to continue implementing my fieldwork also at the Jambi Mascaric center, in Cotacachi, I should have consider the influence of the "Cantonal Development Plan" and of the "Participatory Budget" in the context of its health programme. And, therefore, in this case I should also consider
other issues, in addition to my research questions. This was another reason why Jambi Mascaric has been ruled out of my fieldwork.

Previously, when developing the research proposal, I asked to the coordinator and to a consultant of Jambi Mascaric information of the center, in order to support my proposal. In fact, they sent me data of previous years and information about the future goals of Jambi Mascaric, but they did not mention any of the issues that I have described in these paragraphs.

Cotacachi’s Participative Democracy on the Health Program

Starting the 10th August, 1996, the Municipality of Santa Ana of Cotacachi began a wide process of social participation with the purpose of promoting the invigoration of the democratic collective planning in health (Ortiz-Crespo 2003: 2).

Each year, representatives from various organizations and communities plan the goals for the next year; once they are set, various committees are formed to insure their accomplishment. The Intersector Committee of Health (ICH) was created by the resolution of the first Assembly of Cantonal Unit in November of 1996. One of the main goals of this participative process in Cotacachi has been the health care and, therefore, the development of the Jambi Mascaric center (Borja 1997: 2).
ANNEX 6.3. - People who were interviewed in this fieldwork

<table>
<thead>
<tr>
<th>STAFF OF JAMBI HUASI</th>
<th>STAFF OF JAMBI MASCARIC</th>
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</thead>
<tbody>
<tr>
<td>1. Dr Myriam Conejo: director of Jambi Huasi. She preferred to use her name in my thesis.</td>
<td>1. Mrs. Carmen Cumba: midwife and coordinator of the Health Area in Jambi Mascaric. She preferred to use her name in my thesis.</td>
</tr>
<tr>
<td>2. Carlos: fictitious name of a physician, who works in primary health care and general medicine.</td>
<td>2. Mrs. Juana Morales: indigenous leader and director of the Women Area in Jambi Mascaric. She preferred to use her name in my thesis.</td>
</tr>
<tr>
<td>3. Dr Azalia Vasquez: psychologist. She preferred to use her name, Azalia, in this thesis.</td>
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<tr>
<td>4. Mrs Concepcion Brusti: midwife and “frejadora”. She preferred to use the name “Mama Conchita” in the content of my thesis.</td>
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<tr>
<td>5. Mr Javier Perugachi: yachak of Jambi Huasi. He preferred to use his name in this thesis.</td>
<td></td>
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<tr>
<td>6. Ms Matilde Perugachi: yachak’s daughter. She is 17 years old and she preferred to use her name, Matilde, in this thesis.</td>
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<tr>
<td>7. Mr Darwin Tamba, who is in charge of the information area in Jambi Huasi. He preferred to use his name in this thesis.</td>
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<tr>
<td>8. Mr Vidal Sanchez: practitioner of the traditional indigenous medicine, and “frejador”. He preferred to use his name in this thesis.</td>
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<thead>
<tr>
<th>INSTITUTIONS</th>
<th>INSTITUTIONS</th>
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<tbody>
<tr>
<td>1. Dr Jaime Breith, director of the Health Area at the Andean University Simon Bolivar. He preferred to use his name in this thesis.</td>
<td>1. Dr Teresa Jaramillo, former director of the Cantonal Health System of Cotacachi (until April, 2008). She preferred to use her name in this thesis.</td>
</tr>
<tr>
<td>2. Dr Raul Mideros, researcher and professor in the Health Area at the Andean University Simon Bolivar. He preferred to use his name in this thesis.</td>
<td>2. Marcelo Pinto, coordinator of the Intersectional Health Committee of Cotacachi. He preferred to use his name in this thesis.</td>
</tr>
<tr>
<td>3. Dr Leandro Prieto, researcher and student in the Health Area at the Andean University Simon Bolivar. He preferred to use his name in this thesis.</td>
<td></td>
</tr>
<tr>
<td>4. Mario Conejo, mayor of Otavalo. He preferred to use his name in this thesis.</td>
<td></td>
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<tr>
<td>5. Olga Farinango, director of the Health Area in the Municipality of Otavalo and former physician of Jambi Huasi. She preferred to use her name.</td>
<td></td>
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<tr>
<td>6. Dr Jose Javier Teran, director of the San Luis of Otavalo Hospital. He preferred to use his name in this thesis.</td>
<td></td>
</tr>
<tr>
<td>7. Dr Gonzalo Jaramillo, Provincial Health Director of Imbabura. He preferred to use his name in this thesis.</td>
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<tr>
<td>8. Elizabeth Nuñez, Director of Communication of the Ministry of Public Health. She preferred to use her name in this thesis. She preferred to use her name.</td>
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<tr>
<td>10. Mercedes Muenala, coordinator of the Intercultural Health Area, at the Provincial Health Direction of Imbabura. She preferred to use her name in this thesis.</td>
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<tr>
<th>PATIENTS</th>
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<tbody>
<tr>
<td>1. Mr. Jose Perugachi: fictitious name of a patient of the masseur, Mrs. Concepcion Brusti. He preferred to use a pseudonym.</td>
<td></td>
</tr>
<tr>
<td>2. Mr Jose: fictitious name of a yachak’s patient.</td>
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</tr>
<tr>
<td>3. Mr. Cesar Cotacachi, son of a patient’s yachak of Jambi Huasi. He preferred to use his name in this thesis.</td>
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ANNEX 6.4. Traditional Childbirth in a Vertical Position

Previous status

In 2002, after a meeting between midwives and women of indigenous organizations with technicians of the Provincial Health Direction of Imbabura, it emerged the initiative of implementing the normal childbirth in a vertical position (which is known as ‘traditional childbirth’ in indigenous communities).

The main reason for taking this decision was the rejection of many indigenous women to visit hospitals or health centers for their childbirths. To justify their rejection, some indigenous women presented the following statements:

1. According to them, indigenous people usually do not receive good treatment by biomedical professionals at hospitals, clinics or health centers.
2. They do not like that the doctor prohibit the access of relatives during childbirth.
3. Most indigenous women dislike other people shaving their intimate parts.
4. They feel that the childbirth rooms at clinics and hospitals are very cold.
5. They do not want to risk a caesarean, which in many clinics and hospitals is common.
6. They do not like the white sheets that clinics, hospitals and health centers usually use in childbirth rooms, because for indigenous people the white colour is associated with death.
7. Some indigenous women want to perform rituals before giving birth (as the healing of the so-called bad air, or to take some tea before giving birth).
8. Many women dislike that doctors insert their fingers into the vagina.
9. In indigenous communities people usually do not pay money to midwives for the childbirth care. Therefore, some indigenous women do not like to pay in clinics or private hospitals.
10. Most indigenous women do not like the childbirth practice in a horizontal position (as it is the usual in the biomedical service); they prefer in vertical position.
11. In many indigenous communities, it is customary to bury the placenta of newborn babies near the hearth of the house. But usually at hospitals, clinics and health centers they do not receive the placenta of the newborn baby, so without the placenta they cannot do this ritual.
12. Some indigenous women have difficulty communicating in Spanish.

The above quoted opinions were exposed more than 6 years ago at a meeting held by representatives of the Health Network of the Canton of Otavalo, the San Luis of Otavalo Hospital, the municipality of Otavalo, the Jambi Huasi health center and the UNFPA. But at that time, 65

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65 This practice symbolizes the wish because, in the future, the newborn baby could remember his/her origin and feel affection for his/her families and his/her home.
those institutions did not support the proposal of taking into account the knowledge/practice of vertical childbirth in the formal health system of Ecuador.

In 2003, the Provincial Health Direction of Imbabura started to offer training workshops on interculturalism in health, with emphasis on traditional vertical childbirth.66

These workshops were held in several cantons in the province of Imbabura, but especially in Otavalo because, according to this Provincial Health Direction, 53% of the canton population is indigenous.

Mercedes Muenala, who coordinates the Health Area of Indigenous Peoples within the Provincial Health Direction of Imbabura, recalls that the authorities of the canton of Cotacachi had initially accepted the proposal to include the practice of traditional childbirth in a vertical position at the hospital of the canton, “but the proposal was not met; at the end, it was not supported by the indigenous organization Jambi Mascaric, of UNORCAC”.

In contrast, in the canton of Otavalo the implementation of the proposal has progressed. On October 19th of 2005, the organization International Care, founded after an agreement signed with the Municipality of Otavalo, supported this process with provisions for midwives, materials for care during childbirth and training brochures. Some of the key points during the implementation of this proposal were:

- Socialization of vertical childbirth in 4 cantons of the Imbabura province.
- Registration and training of other midwives in the province.
- Preparation of reports on attentions of pregnancy, childbirth, postpartum and newborn care, by the group of midwives trained.
- Search commitment with the Rector of the Central University of Ecuador, to include the issue of vertical childbirth into the academic program of the Faculty of Medicine.
- Preparation of a guide on vertical childbirth.
- Rapprochement between midwives and health personnel from hospitals of the province, to exchange knowledge.67
- Creation of the Vertical Childbirth Room in the San Luis of Otavalo Hospital, near to the emergency area (to attend patients requiring such care).
- Exchange of experiences on vertical childbirth with midwives of Peru.

66 In these workshops, Raul Mideros and Fernando Calderon worked as instructors, as well as other people who have studies on intercultural health.
67 I had the opportunity to participate in a workshop held at the Asdrubal de la Torre Hospital, in the canton of Cotacachi.
For the implementation of the vertical childbirth practice in the formal health system of the Imbabura province, the Jambi Huasi center was supported by the following organizations: Provincial Health Direction of Imbabura, UNFPA, Municipality of Otavalo, San Luis of Otavalo Hospital, National Direction of Health of Indigenous Peoples, Unicef-ECUARUNARI and the Ministry of Public Health of Ecuador. According to Mercedes Muenala, some limiting factors during this process have been:

- Lack of budget for training and implementing the practice of vertical childbirth.
- Poor knowledge about traditional indigenous medicine of the staff of the Ministry of Public Health.
- Few publications on traditional vertical childbirth in Ecuador.
- Mistrust on the attention of vertical childbirth and on the care of midwives, at the San Luis of Otavalo Hospital.
- Constant changes of the local, provincial and national health authorities.
- Some midwives do not accept the training given by the rural doctors and students of obstetrics schools.
- Poor communication between professionals working at the San Luis of Otavalo Hospital.
ANNEX 6.5. Pictures of informants

Jaime Breilh

Raul Mideros

Javier Teran
Concepcion Brusti: *mamhua, "partera" or midwife of Jambi Huasi*
Juana Perugachi, jakug of the Jambi Huasi health center

_jakug_ in a “limpia con cuy”
Javier Perugachi, *yachak* of the *Jambi Huasi* health center
Nurse and patient, in Jambi Huasi

Dentist in Jambi Huasi

Physician Javier Teran, in Jambi Huasi
Concepcion Brusti as "fregadora" and a patient

Vidal Sanchez as "fregador" in Jambi Huasi, eight years ago

Physician and "parteras" in workshop
Ritual and workshop with doctors and midwives, in Cotacachi
Vertical Childbirth Room, at the San Luis Hospital of Otavalo
Demonstrating positions for practicing the Vertical Childbirth
Myriam Conejo, director of Jambi Huasi, in a community

Myriam Conejo received a prize of the UNFPA, for her work in Jambi Huasi

The staff of Jambi Huasi also received a prize of the Municipality of Otavalo, in 2004