

# “Because it is *our* centre”

## A Chilean case study in intercultural health care

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*Globalisation and modernisation in the field of health care have led to the worldwide structural superiority of biomedicine. In the last three decades concerns have arisen about the loss of traditional medicine. However, local cultures persist in times of globalisation through articulations between local and global forces. Intercultural health care is an explicit example hereof. This article analyses why patients make use of intercultural health care. It is based on a case study, which used semi-structured, in-depth interviews with patients of the Intercultural Health Centre ‘Boroa Filulawen’ located in Southern Chile. The most significant function of this Intercultural Health Centre is that it provides patients with culturally accessible health care in the proximity of their homes. Patients are proud of their centre since it expresses Mapuche culture and Mapuche medicine. The implementation of intercultural health care is an attempt to improve the state of health of the Mapuche people and offers them the possibility to be treated along the lines of their traditional cosmology. The centre under study stimulates power sharing between medical logics and expresses political recognition of indigenous knowledge. Intercultural health care centres are examples of glocalisation.*

*[intercultural health care, Chile, Mapuche cosmovision, cultural accessibility, medical pluralism, ethnic minorities]*

### **Introduction: Intercultural health care**

Processes of globalisation and modernisation have contributed to, what Lee (1982) calls, structural superiority in terms of power, prestige and funding of biomedicine and biomedically driven healthcare. Due to the emphasis on evidence-based medicine and the alliance between biomedicine and the modern state, biomedical health care has a scientific ‘aura of factuality’. Other medical systems are frequently compared to biomedical logic, which is represented as universal and empirically sound (Waldram 2000: 604).<sup>1</sup>

Biomedical dominance nurtures concerns about the loss of traditional medical cultures. Some argue that traditional knowledge gets replaced with scientific world-views and that advancing globalisation will leave fewer opportunities for traditional communities to develop on their own lines (Greig, Hulme & Turner 2007). However, until today the population of the developing world relies heavily on traditional medicine to meet its health care needs.<sup>2</sup> Moreover, traditional medical systems are neither static nor lacking in innovation and seem to persist in times of globalisation (Lock & Nguyen 2010). A way in which local cultures may confront globalisation is through the integration of local and global forms. Global forces are localised in order to fit them into local cultures.

Intercultural health care has become more widespread especially after decentralization of health services became popular, and demonstrates processes of glocalisation (Torri 2011). Intercultural health care ideally refers to the expression 'between cultures', but goes beyond the idea of mere cultural contact. It denotes a dynamic and transversal strategy that considers, deploys, and strengthens knowledge and practices of both biomedical and traditional medicine (PAHO 1998). Intercultural health care refers to practicing two or more medical traditions in one common health care setting. At the level of medical providers, clinics, hospitals, governments and international organisations, intercultural health care is about "exploiting the best of every culture" on a basis of equality and appreciation (PAHO 1998: 201). At the level of patients and households, intercultural health care is a manifestation of medical pluralism and can be defined as a transversal strategy that considers, deploys and strengthens knowledge and practices of both biomedicine and traditional medicine.<sup>3</sup>

Chile represents an interesting example of this phenomenon of intercultural health care. It is the latest contribution of policy-making in an era of working towards a new relationship between the state and its indigenous people (Torri 2011).<sup>4</sup> Around 1850 the Chilean state started its conquest of indigenous territory and exerted its sovereignty over its indigenous peoples for over a hundred years. Only recently, since the country returned to democracy in 1989, did the Chilean government begin to attend to the necessities and demands of its indigenous peoples.

However, dissatisfaction remains about enduring unequal relations in Chilean society. Epidemiological data show that, compared to the rest of the country, communities with the largest concentrations of indigenous peoples have less favourable health conditions. (O'Neill, Bartlett & Mignone 2006; PAHO 1998). Political unrest amongst the Mapuche people from Chile, one of the largest indigenous societies in Latin America, is frequent. The main objective of these protests is cultural sovereignty, i.e. the right to practice traditional ways of living, including language, beliefs and health care. The Mapuche oppose the neo-liberal character of the state and want the state to acknowledge their cultural traditions (Fenelon & Hall 2008).

Intercultural health care can be a means to revitalise and strengthen traditional knowledge and local identities. Moreover it stimulates power sharing between local communities and the state, yet can it be argued that intercultural health care also improves the health condition of the Mapuche people? What do patients themselves think about intercultural health care? There is a substantial lack of research on these

topics. This article therefore explores the patients' perspective on intercultural health care. It investigates the reasons why patients opt for a rural intercultural health care centre instead of a urban biomedical hospital.

## Research setting and method

This article is based on a case study I conducted in Chile (Beerenfenger 2010). The fieldwork was carried out between February and April 2010 at the Intercultural Health Centre Boroa Filulawen (*Centro de Salud Intercultural Boroa Filulawen*, from here on referred to as the IHCBF). Every year at least five hundred families regularly attend the IHCBF (Pichicona, Bustamante & Moscoso 2009). The IHCBF is located in the rural part of the municipality of Nueva Imperial in the region Araucanía. Indigenous peoples in Chile often do not have access to basic health care facilities and the Araucanía region is no exception to this (Pichicona, Bustamante & Moscoso 2009). Araucanía is home to the country's largest concentration of Mapuche people which make up fifty percent of the population. Protests by Mapuche organisations and individuals is a regular phenomenon in its capital city Temuco (O'Neill, Bartlett & Mignone 2006).

The IHCBF works with two health care teams which both have their own infrastructure. The teams are called 'the Western health care team' (*equipo de salud occidental*) and 'the Mapuche health care team' (*equipo de salud Mapuche*). The western team consists of a doctor, a nurse, a nurse's assistant, a dentist, a dentist's assistant and a social worker. A *machi* (Mapuche shaman), a *lawentuchefe* (herbal healer) and occasionally a *pvñeñelcefe* (midwife) and a *gütamcefe* (bonesetter) make up the Mapuche team (Pichicona, Bustamante & Moscoso 2009).<sup>5</sup> During consultations the *machi*, either a man or a woman, determine natural or spiritual causes for illness and analyses the social context of the patients. *Machis* diagnose illness by looking at urine samples, by drumming over the patients' used clothes with their sacred instruments, and by looking into the patients' eyes. If considered necessary *machis* and *lawentuchefes* prescribe herbal remedies. *Machis* also perform healing ceremonies for more complicated illnesses or spiritual afflictions (Bacigalupo 2007).

With twenty-one patients of the IHCBF I conducted semi-structured, in-depth interviews in the Spanish language. Fifteen of them considered themselves Mapuche, six called themselves Chilean or non-Mapuche. Prior informed consent was obtained orally from the IHCBF representatives and from each person interviewed prior to data collection. Interviews took place in a private room in the centre. Furthermore, I held informal conversations with biomedical physicians, traditional healers, staff members, managers and patients, and almost daily carried out participant observation at the IHCBF. I also attended traditional Mapuche healing ceremonies and an assembly of Mapuche representatives who were formulating a law proposal for further recognition of Mapuche healing.

## Mapuche cosmovision

Equilibrium is the central notion in the Mapuche cosmovision: the Mapuche ethos and the way they perceive the relationship between the human, the natural, and the spiritual world. When there is equilibrium in all components of life, that is body, mind, spirit and society, harmony prevails and *küme felen* (health, complete well-being) is guaranteed. In contrast, disequilibrium results in illness and manifests itself generally in *kutran* (lit. pain). There are *Mapuche kutran* and *winka* (non-Mapuche) *kutran*. According to literature on the subject, *Mapuche kutran* are caused by elements that exist in the world of the Mapuche, while diseases labelled as *winka kutran* have been introduced into the Mapuche world through contact with Western culture. Upsetting the Mapuche's ethos, through the imposition of Chilean capitalist values, causes *winka kutran* (Bacigalupo 1998). *Mapuche kutran* therefore belongs to the domain of Mapuche medicine and *winka kutran* to that of biomedicine (Citarella 2000; Bacigalupo 2007; Navarra 2007; O'Neill, Bartlett & Mignone 2006).<sup>6</sup>

My research corresponds to these observations and is in line with outcomes of earlier work in Latin America on folk dichotomies and their social-cultural functions. Folk dichotomies are the rationale for etiological beliefs and treatment strategies that classify some illness categories as incurable by biomedical physicians (Foster as cited in Young & Garro 1982: 1454).<sup>7</sup> These illness classifications are related to cultural identity, as the next quote illustrates:

*Winka medicine* is not satisfactory for the types of illnesses that *we* have because *we* live in the middle of nature right here. (Informant 10)

The *Mapuche kutran* mentioned by the interviewed patients can be considered as folk illnesses. They are linked to supernatural and natural forces and there is agreement among informants on causes and treatment strategies (Kleinman 1980). According to my informants, treatment for folk illnesses is only offered by the Mapuche team, not by the Western team. These cultural bound disorders, which by no means only exist in traditional societies, must be treated in a culturally specific way because they have specific meanings for those who suffer these illnesses, as the following quotations demonstrate:

The doctor will not see the evil eye [...] You can have whatever thing inside of you and go to the doctor and he will exam you, check your urine, everything and no, he will tell you that you are not suffering from anything. But you do feel bad, you don't have energy to get up early in the morning, to go to work or things inside of you hurt and the *machi* will see this. Every *machi* has a power to see these illnesses, either by looking at your urine, pulse reading, looking at you and your clothes. They can cure you with their medicine. Not overnight but sometimes they perform miracles as well. (Informant 16)

When a person transgresses the house of a *ngen* [owners or caretakers of all beings, LB] without asking permission, that is when illness appears. *Machi* are the only one

that can take out these illnesses [...]. Let's say that this forest wasn't a pine tree forest but a forest with native trees that grow from the earth and aren't planted by people. This mountain has its *ngen*, its caretakers, its spirits, which habit inside the mountain. And when a person transgresses the house of this *ngen* without asking permission, illness will appear and the *machi* immediately knows where it comes from. These are illnesses that only *machi* can cure, not even a doctor, no one. You have to go back to this place and perform rituals with the *machi*. (Informant 11)

My informants attribute the causes of Mapuche illnesses to what they call '*drama en el campo*', '*el mal*', '*el mal de ojo*', '*la maldicion*', '*el maldado*' and '*fuerzas malas*'. These concepts can be translated as the evil eye, evil, curses and evil spirits. The patients opine that these illnesses need Mapuche medical treatment, because "every illness had its own remedy" (Informant 9) and "the doctor has nothing to cure evil". (Informant 17)

Biological causes are ascribed to *winka kutran*. Examples of *winka kutran* that were regularly mentioned are high blood pressure, cancer, eye problems, spinal problems, heart problems, broken bones and appendicitis. These ailments are seen as mainly physical and are considered to be in need of 'machines' like scans, x-rays, and surgical equipment. Informants expressed their views on the division of labour as follows: "The illnesses that only the doctor can cure are surgical ones, like operations on the bones." (Informant 17) These kind of diseases are considered to be incurable by a *machi*: "You go to the doctor when you need a more chemical treatment than the *machi* uses to cure." (Informant 19)

All interviewed patients differentiate between *Mapuche kutran* and *winka kutran*, but only less than half of the informants (nine out of twenty-one) mention that they have actually consulted the Mapuche team on one or more occasions. Similarly, compared to Mapuche and intercultural activities, a lot more western health care activities, such as consultations and team gatherings, were registered in the IHCBF (15.250 against 4.596 respectively, see Pichiconá, Bustamante & Moscoso 2009). Two out of the nine informants who visited a traditional healer in the IHCBF, considered themselves to suffer from *Mapuche kutran*. The other seven first consulted the western team and then moved on to the Mapuche team as well. The decision to visit both teams is usually made by the patients themselves. Referral from one team to another takes place only occasionally. The seven informants that went from the western team to the Mapuche team did not consider themselves to suffer from *Mapuche kutran*. They tried both medical traditions, because biomedicine did not give them symptom relief. Another reason for also using Mapuche medicine is that its treatments are seen as less 'chemical' and more natural. Mapuche medicine is based on herbs, animal parts, oils and waters.<sup>8</sup>

We can conclude that my informants did not perceive the different treatment options as mutually exclusive. Moreover, they recognised limitations of both biomedicine and Mapuche medicine.

## Cultural accessibility: “Because it is *our* centre”

The most important reason mentioned by my informants for making use of the IHCBF is that they feel accepted and comfortable. They appreciate the centre’s atmosphere of equality and the fact that everyone knows each other. In contrast, they experienced discrimination and a degree of superiority by health care providers in public hospitals in the region, as the next quote shows:

From this place they sent me to Imperial [The Nueva Imperial Hospital is located around fifteen kilometres km from the IHCBF, L.B.] But we, because we are farmers, because we are Mapuche, they look down on us. If we were people with money, we would take out cash and half an hour later we would be examined and everything would be fine. But because we are farmers, we have to put up with it ... We have to put up with it ... The services there are very bad, because we are always looked down on! I will never again go to Imperial! I prefer to be treated here, I know that here I will be cured. Right now I feel allergic to the Imperial Hospital and I am proud to be here! (Informant 1)

My informants considered the IHCBF as *their* centre. They are proud of *their* centre because it revitalises Mapuche culture and Mapuche medicine even though the latter is not used as often as biomedical care.

I use the term ‘cultural accessibility’ for addressing this experience of cultural and ethical compatibility. Cultural accessibility in the IHCBF is provided by appreciation towards Mapuche culture. Firstly, cultural accessibility is accomplished by offering patients different health care options. Some of which coincide with the explanatory models that are part of the Mapuche cosmovision. Secondly, patients are treated with respect and not as second-class citizens in the IHCBF. Thirdly, in this intercultural centre Mapuche culture is revitalised because its Mapuche section is built according to Mapuche architectural principles and Mapuche artefacts are displayed. Lastly, the IHCBF fulfils a symbolic function by representing the repressed Mapuche culture.

I will now discuss these four aspects of cultural accessibility in further detail.

### *The need for different health practices*

The medical anthropologist Arthur Kleinman proposed the concept of explanatory models (EM) to describe different perspectives on and explanations of diseases by all actors engaged in clinical processes. Different worldviews shape these perspectives and explanations. In Kleinman’s approach, explanatory models of patients are central to their categorisations of disease. Apparently, the cause that patients attribute to his or her health problem steers treatment choice (Kleinman 1980).

Biomedical EMs and treatments are based on scientific evidence and the use of medical technology. The biomedical provider is focussed on the physical dimensions of disease and is less concerned with the illness perspective (see Helman 2007; Kleinman 1980). According to the interviewed patients *winka kutran* are caused by somatic abnormalities and are therefore in need of measurement by machines and biomedical

treatment. In contrast, traditional practitioners share the cosmovision of their communities, including explanatory models. Their approach is usually a holistic in the sense that psychosocial and cultural illness aspects are most important (Kleinman 1980). They give patients meaningful explanations for their health problems and they respond to personal, family and community issues (Kleinman 1980; Helman 2007). Since supernatural and natural forces cause *Mapuche kutran* these ailments are in need of Mapuche medicine.

Subsequently, informants who only used biomedical care (twelve out of twenty-one) stated that they have not yet suffered from health problems that need Mapuche medicine. Interestingly, the majority of this group of people (nine out of twelve) were youths between sixteen and twenty-nine years old. Most of them said that they did not have the opportunity to visit a *machi* because of lack of time or unavailability:

I haven't been to the *machi* yet, but I do really want to see her. But it's difficult, because I'm studying. Now I have holidays and I'm trying to come, but my mother wouldn't let me go alone and she hasn't had the time yet to come with me. But because I am Mapuche I would like to see a *machi* so that she can tell me about the things that are happening to me. I have been treated by a doctor for over ten years now but my headaches don't go away, nothing helps. But if I can go and see a *machi*, she can give me a liquid, a remedy based on medicinal herbs and these have helped me before, my mother gave them to me. I am Mapuche and I do believe in the *machi*. But however I also believe in the doctors. I have a little bit more faith in the *machi* because they can see things that the doctor can't see. (Informant 19)

I have a lot of faith in Mapuche medicine. In Western medicine I don't have a lot of faith... I have faith in Mapuche medicine and a little bit less in Western medicine. [L.B.: So why then have you never been to a Mapuche healer?] I always go to the Western team. Sometimes it might be because of the time; because the *machi* doesn't receive patients at the days when I am sick [...] And I have not suffered an illness that needs to be treated by a *machi*. (Informant 20)

Although *machi* do not work as many days as the conventional physicians, all interviewed patients complained about a lack of staff members in both teams. My respondents stated their belief in Mapuche medicine, their faith in its practitioners, and their appreciation of Mapuche culture. However, researchers and interview contexts influence data. When talking to me, a European woman who is interested in Mapuche medicine, the informants, being social actors, may express what they deem to be a 'correct' cultural opinion, rather than their actual opinion. This might be the case when I interviewed young people who had never visited a *machi* by the time of research, but emphasised their desire to do so.

In conclusion it can be said that there is an explicit need for a variety of health care options among the patients of the IHCBF. This centre provides patients with two forms of health care by offering them the possibility of Mapuche medicine and biomedicine.

### *Respectful social treatment*

As stated, none of my informants ever felt discriminated against in the IHCBF. In contrast, they experienced discrimination in biomedical hospitals of the region: “There is still discrimination in the cities.” (Informant 21) The following quote illustrates these commonly shared feelings:

In the Nueva Imperial Hospital they look at you like ... I don't know ... Here we are welcomed, they greet us. Because we come from the country side, we are farmers and they look down on us. Here they don't, because we are all equal here [...] The Mapuche people are always looked down on. The *winka* always call us Indians, those Indians, it has always been like that. (Informant 15)

Informants told me that it does not matter if one is Mapuche or not. In the IHCBF everyone is treated alike: “I know all the people here and they know me [...] I like the warm atmosphere here, we are all neighbours.” (Informant 6) An important reason for this is that the Mapuche culture is a strong component of the IHCBF. The IHCBF is based on a health care initiative generated by a process of community participation, which is still a spearhead action of the centre. The IHCBF is organised around representatives of sixteen Mapuche communities (Pichicon, Bustamante & Moscoso 2009). In 2010 the director of the IHCBF told me:

This is a Mapuche health centre that offers attention from both systems: *winka* health care and Mapuche health care, but its strongest component is Mapuche. The directors are Mapuche, their administration is Mapuche and when we started we always said that we need our own professionals that come from our own communities.

Biomedical professionals working in the IHCBF said that when staff members are contracted, they are selected because of their empathic attitude towards Mapuche patients. First of all, staff members of the Mapuche team have to be Mapuche themselves and must come from the municipality of Nueva Imperial. Secondly, ideally the staff of the western team should be of Mapuche origin. Or at least they must be professionals who are sensitive to the Mapuche culture and have either working experience or personal experience with Mapuche people. In the course of their career staff members receive additional information on the Mapuche culture, its people, habits and beliefs. Therefore biomedical providers of IHCBF are probably better prepared to work with Mapuche patients than their counterparts working in other medical establishments where this kind of information sharing lacks and Mapuche healthcare providers are scarce.

Both health care teams are expected to treat all patients alike when it comes to waiting and consultation time. Although waiting time could be as long as two hours, my respondents consider this fair because they do not feel discriminated against in the IHCBF. They are confident that they will be served according to the ‘first come, first served’ principle. In public hospitals they experience longer waiting times as the next quote shows:

Half an hour or an hour [one has to wait in the IHCBF]. This is not much. In Queupué [Queupué Post, eight kilometres from the IHCBF] they delay an entire day to help you! (Informant 18)

The amount of time spent with the health care provider is also considered to be appropriate. According to my informants both health care teams spend approximately the same amount of time when treating patients: around fifteen to twenty minutes per visit. Both teams do not discriminate and treat patients as equals. Patients thus experience cultural accessibility once more. In the IHCBF all patients are treated with empathy and respect.

### *Mapuche artefacts*

The physical appearance of the IHCBF also plays a role in creating cultural accessibility. One of my informants stated: “The architecture is according to how the Mapuche lived before. It comes from our ancestors. I like it.” (Informant 11) The informants appreciated the fact that the centre looks like a *ruka*, a Mapuche’s traditional wooden house:

They are trying to incorporate the architecture that was formerly used by the Mapuche culture; the *ruka*, the form, the curves, everything has significance. It’s good that they are trying to recover this, because it’s getting lost. (Informant 19)

A traditional fireplace is located in the centre of the *ruka* for making coffee and tea and a small kitchen offers traditional local food, like *sopaipillas* (fried wheat dough) and *muday* (pine nut juice). Patients that do not consider themselves (fully) Mapuche also feel good in the IHCBF because: “It is a very comfortable place. There is a fire and a kitchen if you want to drink tea or coffee.” (Informant 13) However, it are the Mapuche patients who truly feel that their culture is appreciated because the IHCBF is constructed according to the Mapuche cosmovision and revitalises some aspects of the Mapuche lifestyle.

### *A sign of respect*

As mentioned before, a key aspect of the intercultural program of the IHCBF is the input from indigenous communities in hospital administration. The IHCBF emerged as an answer to demands from Mapuche communities to promote their social and cultural rights. The goal is not only to improve accessibility of services and reduce social inequalities between Mapuche and non-Mapuche populations, but also to restore Mapuche culture. The IHCBF, therefore, represents a clear case of multicultural social policy (Park 2006).

Definitions of multiculturalism vary greatly but “describe processes which allow for power-sharing between different national communities and as a label for policies which aim to promote the position of traditionally marginalised groups” (Baumeister

2000: 36). Multiculturalism in Chile means political recognition of indigenous peoples and strengthening the identity of minorities. Here, intercultural health care emerged as a solution to the less favourable health care conditions of indigenous peoples such as the Mapuche. However, it also deals with the need for expanding citizenship to indigenous peoples in order to democratise the state. After years of a centralist state, the civilian government attempts to show (inter)nationally that it is better than the Pinochet regime. This is done by devoting attention to equal treatment of indigenous populations through, for example, the signing of laws and agreements on intercultural health care (Park 2006).

At the same time the Mapuche people continue to protest against their unequal treatment in Chilean society and attempt to acquire more cultural sovereignty. A discourse on discrimination and exclusion facilitates the construction of the 'true' Mapuche (Terwindt 2009: 237). In this image the 'true' Mapuche lives close to nature, believes in the spirits of the water and the land, lives in harmony with the forces of nature and uses medicinal plants (Terwindt 2009).<sup>9</sup> Intercultural health care in IHCBF promotes the image of the 'true' Mapuche and in this way the centre is a resource for cultural affirmation in a context in which the Mapuche people feel repressed and ignored.

This enables the Mapuche to express their feelings regarding their unequal treatment by the state. They use the discourse on intercultural health care as a way to protest. As such, intercultural health care legitimates the Mapuche in their political struggle. These findings confirm other research findings in Chile that show that the discussion on intercultural health care is also a discourse of discontent and a means to carve out a new relationship with the state (Boccaro 2002; O'Neill, Bartlett & Mignone 2006; Park 2006).

## Availability

Apart from cultural accessibility, availability is another reason mentioned by my informants for making use of the IHCBF. Since the IHCBF is located in a rural part of the country villagers can easily reach the clinic. In contrast, public hospitals and clinics that are situated in towns and cities are difficult to reach. For example, public transport to the closest urban centre, Nueva Imperial, is very limited (buses pass by only three days a week) and there is no public transport at all to another intercultural hospital, the Makewe Intercultural Hospital. Because of this, patients encounter difficulties when in need of medical care. They arrive too late or not at all and lose a day's work. Furthermore, transportation costs money which patients often do not have. In contrast the IHCBF is relatively easy to reach as the next quotes illustrate:

To go to Imperial I have to get up at ten past six in the morning because I have to get a bus about one to two kilometres away from my house, which is twenty minutes walk. At 7.30 in the morning the bus stops over there and at ten to nine we arrive in Imperial. And sometimes the bus back doesn't even show up and then I have to stay there all day and I don't have money to buy food. For that simple reason I prefer to come here. (Informant 7)

We used to go to Imperial, we went to see the doctor there. But what happened is that because of the transportation we always arrived late and never made it in time for our appointment. And therefore we decided to come here to Filulawen [IHCBF]. This is closer to our homes. (Informant 8)

The IHCBF also provides easily access to Mapuche medicine. The Mapuche team is available to the patients at specific times and traditional healers are easy to locate, because they are employed in the centre. Traditional healers working outside the centre are more difficult to locate as the next quote tells us: “Sometimes someone doesn’t know where the *machi* lives or they don’t have the money to pay the transportation. The fact that she works here is easier for us.” (Informant 7)

## Conclusion and discussion

When talking to the patients of the IHCBF it became clear that intercultural healthcare in this centre manifests itself through the medical pluralistic behaviour of the patient. On paper and in an ideal situation, intercultural health care refers to dynamic strategies for strengthening knowledge and practices of both biomedical and traditional health care providers. However, in practice it is not the referrals of health care providers, but the choices of patients that shape medical pluralism in IHCBF. The most significant function of the IHCBF is that it provides patients with culturally accessible health care situated near to their home.

We can conclude that the implementation of intercultural health care in the IHCBF is a positive step towards improving the health of the Mapuche people. The centre offers cultural appropriate care and therefore makes it possible to treat patients in line with their own cosmology. The health care providers in the IHCBF are selected and trained with an empathic attitude towards Mapuche patients in mind. They operate in physical surroundings that express and thereby revitalise the Mapuche worldview. This shows the overall importance of the IHCBF for reclaiming of Mapuche cultural identity.

Intercultural health practices will be of value not only for the health of indigenous peoples, but also boast their identity and self-worth. Intercultural health care has therefore symbolic and instrumental aspects. It is a step towards power-sharing and political recognition, because of its focus on community participation and cultural accessibility. In the case of IHCBF it stresses the importance of cultural rights and emphasises the responsibility of the Chilean government to provide adequate health care to its indigenous peoples.

However, there is a danger that because of the on-going global spread of biomedical logic, Mapuche medicine will increasingly become just a symbolic representation of Mapuche culture, without actually being used. Although there appears to be a need for traditional medicine in IHCBF, biomedical health care has a much stronger presence than Mapuche medicine. This does not mean that biomedicine works like a ‘bulldozer’ replacing indigenous medical traditions. Culture is neither static nor lacking in

innovation and tries to secure its relevance through multicultural social projects like the IHCBF. It remains to be seen if multicultural health care projects will be mainly symbolic. The Mapuche youth of the IHCBF, for example, applaud the revitalisation of Mapuche culture and express their cultural loyalty, but actually hardly ever visit a traditional healer. The fact that biomedicine has gained structural superiority worldwide seems to side-line Mapuche medicine. It seems that Mapuche medicine is often mainly appreciated for its meta-medical messages. This being said, worldwide many patients often use more than one medical system and are inclined to complement distinct medical systems. It seems that the popularity of traditional medicine depends upon its easy availability, its expression of local identities and its expertise in diagnosing and treating folk illnesses.

Taking traditional knowledge serious is an important step in a process of giving more autonomy to local populations to inform their development process (Sillitoe 2002). As an expression of glocalisation the IHCBF stimulates power sharing and demonstrates political recognition of indigenous knowledge. Indigenous knowledge traditions expose the existence of other worldviews apart from the Western one and this recognition promotes the understanding of local social and medical problems.

## Notes

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- 1 According to Clifford Geertz (as cited in Swidler 1986) culture provides a model of and a model for experience; culture shapes actions, which lead to experiences which reinforce an ethos. Such an ethos makes a particular worldview plausible, thereby legitimising the culture of a bounded group of people. Medical systems can also be regarded as cultures. They are shared by groups of people, professionally or regionally bounded, which agree on disease categories, disease explanations and treatments which in their turn reinforce the medical notions on which these practices are based (see Bode 2011).
- 2 In this article I use the WHO's definition of traditional medicine: "Traditional medicine is the sum total of knowledge, skills and practices based on the theories, beliefs and experiences indigenous to different cultures that are used to maintain health, as well as to prevent, diagnose, improve or treat physical and mental illnesses. Traditional medicine that has been adopted by other populations (outside its indigenous culture) is often termed alternative or complementary medicine." (WHO 2008)
- 3 The diversity of a country's medical system and the many combinations in which patients seek them and healers use them, is usually referred to as 'medical pluralism'. This term suggests equality and fair competition between medical traditions, but this is not the case since biomedicine has the support of the state and shares in the prestige of modern science (Bode 2011).

- 4 According to the 2002 census Chile is home to eight indigenous populations, which together comprise 4.6 per cent of the total Chilean population. These are the Mapuche, Aymará, Atacameño, Quechua, Rapa Nui, Alacalufe, Colla and Yamana. The Mapuche people are the most numerous, not only in Chili, but also in other parts of Latin America. They represent 83.5 percent of the Chilean indigenous population. Many Mapuches reside in the Araucanía region of the country; the Mapuche people represent around 50 percent of the total population of this region (O'Neill, Bartlett & Mignone 2006).
- 5 The *machi* is an authority in Mapuche medicine and also in charge of the Mapuche philosophy, religion and science. He or she is a Mapuche shaman, a mediator between the physical and the spiritual worlds. The *lawentuchefe* is a traditional Mapuche healer who has detailed knowledge of medicinal plants, a herbal healer. The *pvñeñelcefe* is a traditional Mapuche healer who treats pregnant women. The *gütamcefe* is a traditional Mapuche bonesetter.
- 6 Some researchers remark that the boundaries between biomedical and traditional healthcare are not always very clear and depend on the evolution and/or origin of the illness. The anthropologist Bacigalupo, for example, states that: “[...] today there are machi and lawentuchefe who treat mild winka illnesses with medicinal herbs. On the other hand, Mapuche illnesses that produce serious symptoms with major organic alterations are also classified as winka kutran” (Bacigalupo as cited in Navarra 2007: 14). Influences of modernity and the dominant position of biomedicine result in constant reinterpretations of the apparent static Mapuche cosmovision.
- 7 See also the recent work of Mathez-Stiefel, van de Broek & Rist (2012) on health seeking behaviour in rural Andean communities in Bolivia and Peru. These authors come to similar conclusions.
- 8 From my own research I am not able to tell with certainty if the opinion of patients on the cause of their disease changes when they shift from one medical system to another. However their perceptions of their ailments certainly change when there is no cure or symptom relief.
- 9 The image of the ‘true’ Mapuche does not necessarily correspond to reality. It can be seen as a political strategy to (over) communicate ethnic identities (Terwindt 2009).

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