"All they want is to be treated well"

Public health care in the rural Ecuadorian Andes

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Contents

Abstract

In thesis I describe the meeting between biomedical health care and indigenous patients in rural Ecuadorian Andes. I show how biomedical conceptualization of health and good treatment differs from local understandings. Ecuador is a hierarchical society, where marginalization of the indigenous population has become naturalized. In the community where I did my fieldwork this marginalization became visible through health care. Firstly rural areas have been, and are, under prioritized in terms of staff and medical equipment. Secondly, poverty is a huge strain on the peasants' health. Hard work wears their bodies out, and they have no access to safe drinking water. At the public health clinics the patients are met by a doctor who often scolds them for not taking care of themselves rather than addressing their illness. Many patients are afraid of the doctor, who in turn is frustrated because the patients do not come to the clinic, making it necessary to seek them out in their homes.

At first glance the distance between patients and doctor seem enormous. But there are health agents who can bridge this distance. *Auxiliares de enfermería* (nursing assistants) mediate between biomedicine and Andean conceptualizations of health and sickness. They are trusted by the patients, and work to encourage them to seek out public health care. In this thesis I argue that until medical doctors are able to be culturally sensitive, it is vital for good health care to employ local health agents. At my fieldsite this role was filled by the auxiliares de enfermería, who not only assisted the doctor and translated for her, but functioned as medical authorities in the communities. Their work bridged the gap between patients and doctor, local beliefs and biomedical practices.

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Glossary

Identities

Mestizo – mixed Spanish and indigenous heritage. Nowadays often used about every non-indigenous person. An upper-class "mestizo" might be referred to as white rather than mestizo.

Kichwa – I use the word Kichwas to describe Kichwa speaking people. To not confuse the readers I have chosen this orthography also when mentioning Peruvian or Bolivian Quechua speakers (but left the original orthography in direct quotes). It should be kept in mind however that there are differences between Quechua/Kichwa speaking cultures both across and within country boarders.

Campesino – Peasant, generally poor and indigenous

Medical practitioners

Yachak – healer with spiritual powers. (andean shaman). The word "*yachak"* is Kichwa and is translated to "*sabio"* in Spanish, or "knowledgeable" in English.

Curador – healer without spiritual powers

Sobadora/fregadora – bone setter

Auxiliar de enfermería – nursing assistant

TAP (technicos de atención primaria de salud) – technicians in primary health care. Locals doing health promotion and sickness prevention

About medical anthropology[1]

Disease: refers to abnormalities in the structure and/or function of organs and organ systems; pathological states whether or not they are culturally recognized; the arena of the biomedical model.

Illness: refers to a person's perceptions and experiences of certain socially disvalued states, including, but not limited to, disease.

Sickness: is a blanket term to label events involving disease and/or illness.

Etiology: the explanation given by doctor, healer or patient in reference to the cause of the disease.

Other

Minga – community work (similar to the Norwegian "dugnad"). In Toa people now got fined by the local government if they did not show up to mingas.

Kamkawa – hard soil

Ayllu - family, community

[1] Definitions from Young (1982)

Map of Ecuador[2]

[2] Source United Nations (2014a)

Chapter 1

Introduction

In February, almost two months after I finished my fieldwork in Ecuador, Jessica called me up on Skype. Her nephew was born. *"Congratulations!"* I said. *"Why? It was horrible. Normita had to give birth in the hospital and they cut her. Now Mama is sick with sorrow and worry." "Oh, I am so sorry to hear that. Do you mean they did a caesarian section?" "Yes, it's really bad for the body, and the doctors do it just to earn some extra money."*

Childbirth – when the natural becomes unnatural, an introduction to conflicting health care

In Ecuador giving birth is seen as one of the most natural of all human (female) experiences. At my fieldsite Toa[3], a rural community in the central highlands, women were just recently starting to give birth at hospitals. Most mothers under 30 had given birth both at hospitals and at home. When women chose to deliver their children at hospitals there were two main reasons. Firstly, there was pressure from biomedical doctors. Secondly, some women ended up at hospitals if something went wrong during labor. In the case above, Normita had moved to Quito with her husband after they married. Therefore she was outside her parents control or influence. When her child was to be born, she followed her doctor's advice and chose to give birth at a hospital. For Normita's family, and especially her mother, this was so traumatic that they were unable to feel happy about the new family member. I see this as an example of how

[3] In this thesis I have chosen to use a pseudonym (Toa) when referring to the parish were I worked. This is done to protect the identity of individuals.

important not only health care is for people, but in a wider sense; being properly cared for. The choices people make have greater meaning than simply whether or not they get cured (or in this case deliver the child safely). It is also about culture, world-views, tradition, marginalization and power.

In this thesis I explore the relation between members of an indigenous group, Puruwa-Kichwas[4] of Toa, and the health care they have access to. My main focus will be on biomedicine, but to understand the Puruwa-Kichwas' relationship to biomedicine, one also needs to understand Andean medicine, and how Andeans conceptualize health and illness. I find it useful to introduce this subject by looking at birth because here we can start to get a notion of how conflicting views and unequal power-relations play out in a health care situation.

Traditional norms indicate that a woman should not leave the house for 40 days following birth. During this period she should also attain to other specific taboos and practices, for example not touching water and keeping a set diet. This practice is not unique for Toa, but has been described from other parts of the Andes (see e.g. Larme and Leatherman 2003, Quintero and Roulet 2006). Because of the restrictions put on new mothers, relatives assist them with washing the family's clothes, cleaning the house and cooking. Receiving help allows the woman to stay in bed, get rest and restitution, and also reduce the risk of illness. Women are seen as being in a weakened state after birth, thus making their bodies susceptible to illnesses from excess "heat" or "cold" (Larme and Leatherman 2003). In modern Toa these cultural rules are difficult to follow. First of all, a growing number of people are employed outside the agricultural sector. This makes it difficult to get the help needed to stay in bed, not cook or clean, for 40 days. As Graham (2003) has pointed to, the period might also be shortened because poverty makes it difficult to follow the strict dietary rules of this period (such as not eating "*mestizo*[5] food"). Further, women are highly encouraged by biomedical doctors to give birth at hospitals something that makes it difficult for them to maintain traditional practices. In Bolivia for example a woman's first meal after giving birth should always be a strengthening sheep soup (Bastien 1987). Further, giving birth outside their homes means they have to expose their bodies to potentially harmful winds (*mal aire*), heat and cold on their way home.

[4] The Puruwas were the people who lived in and around Toa before the Incan conquest in 1492 (the Spaniards did not arrive in Ecuador until 1534).
[5] The word "*mestizo"* is derived from the Spanish word "*mestizaje*" (mixture). Originally it referred to a child of a Spanish man and "Indian" woman. Now it is used to describe the non-indigenous Latin American population.

Women are especially vulnerable after childbirth because they have lost strength through their blood-loss, and therefore particularly susceptible to illnesses such as *mal aire* (Larme 1998). The opening of the body during birth also provides a temporary space where "heat" and "cold" can easily enter and cause sickness (Larme and Leatherman 2003). If the natural opening during birth is bad, medical opening (caesarian section) is worse. Giving birth by C-section means going through surgery, and as Miles argued "[s]urgery in public hospitals, which is all that poor patients can afford, is seen as a prelude to death, not an extension of life, and patients openly resist it" (1998:216). In general people are not afraid of delivering a child; it is seen as something natural. The fear arises when control over their bodies is being transferred to biomedical personnel. As Murray (2012) has shown, in Chile, once the woman is at the clinic/hospital, her role is reduced to that of a patient, and she will have to accept the decisions of the personnel. Sheper-Hughes writes that in Brazil C-sections are so common among middle and upper classes in Brazil, that poor women complain of "medical maltreatment" when they are forced to give vaginal births (Scheper-Hughes 1992). In Toa, as mentioned, people preferred "natural" births; the common factor here is that the decision frequently is taken away from the women.

Birth in hospitals was by some Toas seen as more risky than home births: "*They say that they yell too much in Riobamba*," Jessica (26) told me. "*And they cut too much. It is not natural and it damages the body*". As mentioned, she also believed that doctors performed caesarean sections just to earn some extra dollars. This belief is not limited to Jessica and her family but is a widespread belief all over Latin America (Iselin Å. Strønen[6]). Many doctors also schedule caesarian deliveries for their own convenience (O'Dougherty 2013).

As we can understand, there are several reasons why people approach hospital births with skepticism. In rural areas where biomedicine has been recently introduced there is a conflict between local beliefs and practices, and the biomedical (often state supported) advice people are given. Childbirth exemplifies how traditional knowledge and practice come into conflict with biomedical recommendations: the state exhorts doctors to get their patients to give birth in hospitals as an effort to reduce mother and child mortality. At the same time peoples' valorization of the natural, their fear of being "opened up" and their skepticism towards

[6] Presentation at Kvarteret 08.04.14, and personal communication.

doctors' motives make them unwilling to comply. Even so, the patients' inferior status relative to the doctor often makes them virtually unable to refuse[7].

This thesis will explore biomedical health care in a rural Ecuadorian village. Sometimes biomedical practice comes into conflict with peoples' conceptualization of sickness, health and good health care. For the patients, the most important thing is to be treated well, both in the sense of being cared for, and being physically cured. Throughout the thesis I will show how biomedicine is unsuccessful in granting the patients' wish for caring treatment. I will also show how the doctor and the patients' perceptions of good health care differ, and how this is influenced by social inequalities.

Ecuador is a hierarchical society where whiteness, wealth, education and urbanity are seen as naturally superior attributes, and a doctor's poor treatment of her patients can pass unchallenged. In chapter 4 I will look at cases were social hierarchies influence doctor-patient interaction at health clinics and hospitals, and see how the patients accept hours of waiting, verbal abuse and to a certain degree also professional mistakes. I try to understand and explain why people choose biomedical health care despite discriminating attitudes from doctors as well as treatments and etiologies that are foreign to them.

I argue that the presence of local *auxiliares de enfermería* (nursing assistants) helps mediate between social and conceptual differences and inequalities in health care. Their presence is vital in making people *want* to seek biomedical treatment. The *auxiliares* reach out to patients who would otherwise not seek biomedical health care, with e.g. vaccinations campaigns. They also visit people in their homes, assess their health situation and encourage patients to visit the clinics. At the clinics they serve as translators, and support for the patients, who often experience reproach from the doctor. My empirical findings show that there are great gaps between the biomedical model of health care and local conceptualizations of health and good treatment. This gap is further widened by the social distance between doctors and patients. I demonstrate how a health agent who can reduce these gaps is vital to rural health care.

[7] I will elaborate on this in chapter 4.

Theoretical backdrop

Andes as a cultural region

The Andes is a mountain range that stretches through the entire South American continent from Venezuela in the north to Argentina in the south. The Inca Empire (Tawantinsuyu) extended throughout the region (excluding Venezuela), resulting in similar cultural traits across borders. Ecological adaption to the high altitudes and harsh climates have also contributed to the cultural similarities. Various indigenous groups inhabit the region, with Kichwa[8] and Aymara as the main indigenous languages. In a review article Murra (1984) points to the fact that Andeans have needed extremely high agronomic competence to be able to produce enough food for large societies above 3200 meters, with over 250 frost-nights a year. Much of this knowledge has disappeared during the last 500 years and might be one of the reasons why many Andeans find themselves struggling to keep above subsistence level. Andeans have always utilized different climatic zones and exchange produce with peasants form other altitude levels (Bastien 1982, Murra 1984). These features of Andean societies has made ethnography from the area largely focused on "reciprocity (especially in labor, but also in gender roles, and ritual practice), complementarity (of production strategies, ecological zones, and later gender roles) and social cooperation and exchange" (Miles and Leatherman 2003:5). As will be shown throughout this thesis, these features of society are also visible in the way people conceptualize health and interact with health professionals.

Why study health care in the Andes?

The Andes is an interesting region were large modern cities are situated in valleys, surrounded by small communities plagued by poverty and social stigma. The stark contrasts make it an ideal setting to study health care from a social perspective, especially because of its traditional practices and high degree of medical pluralism. Andean medicine has traditionally been stigmatized by the Ecuadorian mestizos; the ethnic group that throughout history has dominated social, economic, religious and political spheres. *Yachaks*[9], Andean healers with spiritual powers, have often had to heal in secret to avoid accusations of witchcraft. One man told me that the Christian religion threatened the *yachaks*: "*There cannot be yachaks because creationism says that God is the only one who cures."* In recent times they have also been in

[8] Earlier spelled Quichua, Quechua in Peru.
[9] *Yachak* is Kichwa and is translated to *sabio* in Spanish, or knowledgeable in English.

danger of being legally prosecuted if something goes wrong and the patient's condition worsens. One therefore seeks out *yachaks* through connections and the meeting is defined by mutual trust. Throughout the last centuries the role of the traditional healers has gradually diminished. However,

> biomedicine has not managed to eclipse other systems completely, in part because of its very associations with institutionalized power. Doctors are perceived by the poor as being remote and unsympathetic, or, alternately, of seeking to exploit the sick and poor for profit (Miles 2003:115).

People navigate between various curing techniques, often during the same illness episode. The medical choices people make may influence their social status, and occasionally even their ascribed "ethnicity" (see e.g. Crandon-Malamud 1993, Crandon 2003, Greenway 2003, McKee 2003, Price 2003). As will be discussed, ethnic boundaries are flexible, and social mobility can be achieved in Ecuador by ridding oneself with "indigenous attributes". This also includes choosing biomedicine over Andean medicine.

In Ecuador different healing modalities borrow from each other. Miles (2003) has familiarized us with traditional healers who set up consultation rooms mimicking a doctor's office. She has also shown how natural medicine is packaged and sold in a similarly to pharmaceuticals, increasing its perceived potency (Miles 1998). Further, traditional healers (e.g. La Venadita (Quintero and Roulet 2006), who lived and practiced outside of Quito) frequently use prayer to the Christian God in their healing rituals.

The best argument for studying health care in the Andes *now*, is that what has been written largely describes a world that has long since changed. The most complete work on health in the Andes, since the edited collection by that very same name from 1981[10] is *Medical Pluralism in the Andes* (Koss-Chioino, Leatherman et al. 2003). In addition to being a tribute to Crandon's work (1993) in Bolivia, the latter was an update and actualization of the field of medical anthropology in the region. "Much of the work found in that volume [*Health in the Andes*] occurred in the 1960s and 1970s, in very different political, economic, as well as theoretical contexts from the 1980s and early 1990s when most of the research represented in this volume was carried out" (Miles and Leatherman 2003:3). Following the same argument,

[10] Bastien, Joseph William and John Donahue (1981). Health in the Andes, American Anthropological Association, Special Publication nr. 12.

and regarding the continuing rapid pace of change in the Andes, there is a need for a new actualization of knowledge. Furthermore, as Kathryn S. Oths (2003) points out, most work in the Andes has been done in ethnically heterogeneous towns. My fieldwork was done in a small and (self-defined) 100% indigenous rural community where hardly anyone lived in the parish center. This thesis can thus contribute to a different and updated perspective on matters related to health in the Andes.

Medicine and social inequality

While much of the previous work done in medical anthropology about the Andes has focused on pluralism (and following Crandon (1993) social mobility based on medical choices), I have chosen to study biomedical health care. A few studies have been done on this subject in the Andes, e.g. Paponnet-Cantat's (1995) article on *How health care really works.* She describes how utterly inadequate health care in rural areas can be. Her fieldwork was conducted in the mid-1980s, around the same time as biomedical health care was first introduced at my fieldsite. Paponnet-Cantat describes the malpractice of a mestizo *sanitario* (health practitioner) with only 5 years of primary school and a few months of biomedical training. She argues that due to physical and political remoteness, the Peruvian government under-prioritizes Andean communities, resulting in inadequate and even dangerous medical practices (Paponnet-Cantat 1995). In addition to this she shows that the *sanitario* exploits his position of power to demand "gifts" from poor patients, and castigate them if they do not comply. Papponet-Cantat contrasts her own findings to those of Crandon-Malamoud and states that in Peru "social relations are rigidly established" and rather than providing an opportunity for a negotiation of identities medicine "is one powerful mechanism for maintaining political hegemony and social differences" (ibid: 132). The situation Papponet-Cantat describes is more extreme in terms of bad biomedical coverage in rural area and discriminating attitudes towards the patients than I found in Toa. It nevertheless highlights that there have been, and still is, a structural violence in medicine towards the poor, and especially the indigenous in Latin America.

Critical medical anthropology and the political economy of health

In this thesis I focus on biomedicine, and specifically on how marginalization becomes visible at health clinics. I also look at how poor health is linked to social inequalities. My work contributes to the field often referred to as critical medical anthropology. Critical medical anthropology's main focus is not only biomedicine, but "how political and economic structures creates inequalities in health (…) and how these are faced – or not faced – by the surroundings" (Ingstad 2007:210, my translation). Ecuador is a very hierarchical country, and these inequalities manifest themselves in health care. Being poor and living in rural areas not only signifies numerous challenges to health and wellbeing, but also limits one's access to health care. Singer and Baer, coiners of the term critical medical anthropology defines it as an anthropology which "emphasizes the importance of political and economic forces, including the exercise of power, in shaping health, disease, illness experience, and health care" (Singer and Baer 1995:5). This is the direction I follow in this thesis.

Morgan defines the political economy of health as a "macroanalytical, critical, and historical perspective for analyzing disease distribution and health services under a variety of economic systems, with particular emphasis on the effects of stratified social, political, and economic relations within the world economic system" (Morgan 1998:107). One of the anthropologists that have done this best is Scheper-Hughes. She points to a structural violence where poverty and marginality forces the women of Alto do Cruzeiro, a Brazilian shantytown, to develop coping mechanisms to deal with incredibly high infant mortality rates (Scheper-Hughes 1992). The inability to save their children leads mothers to find support in a discourse about children being born without a "knack for life" soon to turn into angel-babies (ibid). In this thesis I argue that being marginalized as poor, rural and indigenous, the people in Toa, like the Alto do Cruzeiros, face a structural injustice. Until recently, there has been no political will to address poverty and health in rural communities. Throughout these pages I wish to show how poverty prevents good health, and social stigma further deteriorates the situation, hindering good health care.

"Race", "ethnicity" and social inequalities

As Paponnet-Cantat's (1995) study showed, the inherent inequalities of Latin American societies have profound effects on rural health care. These inequalities are based on "race", "ethnicity", "culture", "wealth", "education" "urbanity" and so on, and all of them greatly impact upon health care at my field site. However, neither of them are words that can be uncritically applied. An elaboration of what the terms mean, have meant, and how they will be used in this thesis is thus called for. The word "race" was not used in European languages until the early 16th century, and for about 200 years it was rarely used at all (Wade 2010). The original use of "race" was not associated with physical appearances, but with kinship, a biblical influence, were Abrahams descendant were not referred to as his kin, but as his "race and stock" (ibid). Following Goldberg's argument that the concept of "race" is intrinsically tied to modernity, Wade writes that "[h]uman identity and personhood became increasingly defined by a discourse of race (…) and race could define certain people as fit for slavery" (2010: 8). In the 19th century people started seeing race as type, not lineage, and the hierarchical ordering was increasingly based on 'biological' differences (Wade 2010). "This was the age of scientific racism when 'even for self-proclaimed egalitarians, the inferiority of certain races was no more to be contested than the law of gravity to be regarded as immoral'" (Barkan 1992 in Wade 2010:9). Within anthropology a debate raged about whether there existed races of men that were unequal in origin (polygenicism) or if we all shared a common ancestry (monogenicism). The debate got so heated that it eventually "led to a fracturing of the Anthropological Society of London" (Singer and Baer 1995:16). The methodology of measuring human skulls, which was supposed to provide evidence for "racial differences", was taken up by Franz Boas, and used to prove the opposite. Later the study of genes revealed larger variations within the "races" than between them. Eventually most natural and social scientists agreed that races do not exist in any biological sense but are social constructions (Wade 2010:12). Wade makes an interesting, if simplified, comparison by stating that in North America a person is defined as "black" if they descend from a black person, while in Latin America such categorizations are based on appearance (ibid). Since appearance is more than just skin tone, and over 500 years of genetic mingling ensures that "[a]ll social groups show a mix of physical phenotypes" (Price 2003:212), "racial" categories are fluid. To improve one's social standing is sometimes referred to as *blanqueamiento* – whitening (see e.g. Price 2003, Leinaweaver 2008). This indicates that while stigmatizing people according to "race" is no longer acceptable in Ecuador (the 2008 constitution forbids

it), social status and stigma still follow old "race" lines, and class positions are "racialised" by their association with particular appearances. Although as outlined below, the relationship between "race" and class is complex, its basic features are that the higher the class position, the stronger association with "whiteness" and European features, while low class positions have strong associations with dark skin and indigenous features.

Due to the connotation of the word "race" with racism and colonialism the word has often been substituted by "ethnicity" (Wade 2010:15), a term generally accepted to denote cultural differences. The problem however, is that "ethnicity" often implies both "nation" and "place" and therefore the boundaries are fluent (Wade 2010). A person may define oneself as "Ecuadorian" in contrast to "Peruvian" pointing to cultural differences between the two countries. Simultaneously the same person may be conscious of "ethnic" differences between *mestizos* and indigenous people within the country, and identify more with foreign mestizos than neighboring *Kichwas*[11]. In Ecuador the concept of "ethnicity" is further complicated by the ties of indigenous people to rural areas. A Kichwa, who moves to a city, learns Spanish and adopts western-style clothing, can thus eventually be labeled *mestizo* (Price 2003). Social mobility is acquired by ridding yourself with all that is associated with "indigenous people", and adopt practices that are connected to the perception of what it means to be "white", that is, speaking Spanish, dressing in western clothes, living in cities, being educated, rich, male. Ethnicity is a socio-historical construct (Stolcke 1993) and in the Ecuadorian context ethnicity is an identity open to navigation and change (Price 2003). People may refer to themselves and others as *runa, indigena, natural, cholo, mestizo, bien educado* or *blanco*, among other terms, according to their way of dressing, level of education and also preferred language (Stark 1981). The ways people identify themselves and are described by others may not always correspond, although the elites seem to be consistently *blanco*, and the lower class *runa* or *indigena* (ibid). The relationship between social status and skin color is, in other words, complex in the Ecuadorian context. This may be why "[m]ost people try to avoid using explicit ethic labels"(Price 2003:213). To summarize this; inequality based on "ethnicity", "race", gender, language and social and economic status is closely connected in Latin America.

[11] I use the word Kichwa to describe a Kichwa speaking person. The people at my fieldsite Toa (a pseudonym) referred to themselves as Toa, Kichwas, and Puruwas interchangeably (pointing to village, language and ethnic origin respectively). They sometimes referred to themselves, and were referred to by others as *Runa*. "*Runa*" means "person" in Kichwa but because it is sometimes used in a discriminatory way (e.g. "I am man, you are *runa*" I have chosen to avoid the term.

By using the term “ethnicity” instead of “race”, prevailing racism tends to be downplayed (Stolcke 1993). I have therefore chosen to use the word “race” throughout the thesis, not because I believe in racial differences, but because the Ecuadorians themselves do.

Entering the field

Only five minutes after the car started climbing up the steep hill from Shiricá, one of the girls yells something to the driver and we stop. The two girls exit the car, and nothing happens. "You are supposed to get off here as well" the driver, Miguel, laughs at me. Confused I look to the dentist, sure that I was supposed to follow her and meet the doctor at the clinic. "Not today" the driver says. I get out, and the car with the only familiar face drives away. Well they warned me that things don't always go as planned on fieldwork, I think. I looked around, most of the houses were placed along the road, and there was a dead dog in the ditch. I took a moment to contemplate that soon all these things, the eucalyptus trees, the fast driving camionetas *(pick-up trucks) filled with colorfully dressed and chatting people, the small brick houses, even the dead dog that no one seemed to care about, they would all soon be familiar to me. This was where I was going to live.*

The two local girls explained that our task for the day was to visit houses where there lived pregnant women or malnourished children under five. We were to ask them if they could prepare a small piece of land so that we could plant vegetables and herbs.[12] *We stopped by a small tin-roofed house. Several dogs came barking, and Jenifer picked up a stick to keep them at bay, while yelling "*samunshuuuuun*" to announce our presence. A woman came out laughing with a wet toddler wrapped in a towel on her arm, who she was obviously in the process of bathing. An older child hid behind her long skirt while a third shyly approached us. The dogs calmed down the minute she greeted us. The conversation was carried out in Kichwa and I could not even separate one word from another. We followed the woman to the other side of the road, and after some pointing she said that we could probably use a few square meters, but she had to talk to her in-laws first as it was their land*[13]*. We walked together back to her house, and entered a footpath that started right below it. We had to walk almost 30 minutes uphill to the next house on our round.*

[12] The local diet is greatly composed of carbohydrates: local grains such as corn and barley, in addition to potatoes and rice

[13] In Toa both women and men inherit land when they get married. As they follow patrilocal settlement patterns nearby fields are often either the husband's, or his family's. The woman's land is often far away.

At 3200 meters we were inside the clouds and it was foggy and cool, with slight rain. I appreciated the cool weather as walking up the steep footpath at these heights was unexpectedly exhausting. I did not know if I should laugh or cry when we were passed by an old barefoot woman carrying a burden three times her own size. The striking poverty that surrounded me, the long distances, the multitude of fierce guard dogs, the thin air, the wet, the cold, and the unfamiliar language shredded all romantic ideas of fieldwork in the Andes during this first hour. (Fieldnotes 02.06.13)

The fieldsite

I based my fieldwork in the parish of Toa, outside of Riobamba, the province capital of Chimborazo, Ecuador. Chimborazo is the province with the highest percentage (38%) of indigenous population in the Ecuadorian highlands (INEC 2014), which often was stated as one of the reasons why traditional knowledge and beliefs (especially medical) have a stronger role here than elsewhere in the country.

The parish of Toa is divided into 23 communities[14], which are categorized as lower, middle or higher communities. This distinction is relevant as climate varies, and with that, the conditions of livelihood. The higher communities are characterized by limited vegetation, strong winds and a population who mostly work selling vegetables in the city. The middle and lower communities have a milder climate, and although their access to cash is not necessarily better, their lives are to a certain degree more comfortable. The earth yields more produce and night frost is rarer. Transportation is also more frequent in the middle and lower communities. Each community has a catholic and an evangelic church, a community house and a tiny shop where you can by mostly sweets, but also provides an (expensive) supply of staple foods such as flour, cooking oil and eggs. Most communities have a primary school, while kindergartens and high schools are concentrated in a few central places.

The community where I lived was the second on the way up from Riobamba. It is counted as a middle community and is fairly central as it has the largest high school with a few hundred students (the only other high school has under 30 students), all the buses passes by, and it is

[14] Some numbers calculate only 19 communities, but I use the number 23 to count all the communities who has some form of rights (water or voting) in the parish.

only a 15 minute walk to the parish center. It has better water supply than most other places, although it is far from perfect. It is difficult to calculate the number of inhabitants as migrants "come home" to do the census, rendering the numbers unreliable. Pedro, who worked collecting water fees, estimated the population to include around 50 households. Parish statistics count a population of 172 people, making it a mid-size community[15]. The community had one paved main road, with the two churches almost at opposite ends. Those not living by the road accessed their houses either by dirt roads, or by *chakiñan* (K-footpath)[16]. Because it was one of the few communities who had enough water to have a rotation of irrigation water, food production was fairly good. After alfalfa for the guinea pigs, most land was used for potatoes, corn, peas, broad beans and beans. At the time of fieldwork quinoa seeds were sold below market price to incentivize people to plant more of this highly nutritious grain sort. There was also a distribution of blackberry plants with the intention of selling the berries at city markets.

Change and development

Since the prime of the Puruwa-kingdom, before the Inca-conquest in 1492 and some 42 years before the Spaniards arrived[17], Toa has undergone several changes, many of them in the last few decades. If we start with "the beginning" of Toa's history we find a fertile valley of kings. The land is said to have been green with plenty of water, filling up lakes and a multitude of rivers. This was all destroyed in 1640 by a natural disaster, most likely a tectonic collapse, causing mountains to disappear, creating huge gorges and burying houses and people. The landscape was changed so much that property lines became unrecognizable[18]. In 1977 there was a new disaster; an earthquake caused yet another part of Toa to collapse, killing approximately 20.000 people in the central highlands[19]. The earth is still unstable and there is a very real possibility for new collapses.

35 years ago, at the time of the last collapse, the land was still fertile and there were no trees, only high grass and straws. Now, eucalyptus-trees dominate the lower parts of Toa, and many

[15] Population per community ranges from 48 to 560 (2012). Information from a parish development document that I cannot site, because it would compromise anonymity.
[16] As will be explained later, all translations from Kichwa are marked in this thesis with a "K" while translations from Spanish are left unmarked.
[17] Riobamba was founded in 1534.
[18] From parish development document (2012).
[19] From parish development document (2012).

blame them for "*sucking all the water*" away[20]. Others say periods of heavy rain and the strong winds have eroded all the fertile earth. No matter the reason, the fact is that fertile land is scarce. Areas that used to be productive have now turned almost to stone: A condition referred to as *kamkawa* (K- hard soil). Some say the land turns to *kamkawa* because many migrate and do not take care of their land. The part where the *kamkawa* has not completely turned to arid stone, it is still rock hard which makes preparing the land with a pick axe exhausting. At the time of fieldwork the few rivers had been reduced to tiny creeks. It had not rained properly in two years, people said, but they hoped it would rain in February, it usually did, and that the rivers would fill up again. The arid hills of Toa are not optimized for farming and, the roads are bad and transportation rare. Many migrate to the big cities or foreign countries such as Venezuela, Spain and the United States.

Picture[21]: A dry landscape

In the 1960s people started converting to evangelical Christianity, the now dominant religion (75%, the rest are Catholics). The Toas were converted by the Gospel Missionary Union (GMU) who established themselves in Colta, close to Riobamba, in 1953 (Muratorio 1981). Muratorio explains the rapid conversion rate with Protestantism's focus on ethnic pride, individual relationship to God, and the GMUs establishment of schools, hospitals and a Kichwa radio station (ibid). This radio station was still heard from houses and cell phones all

[20] Eucalyptus is widely reported to cause drought. See e.g. R.E.A.L Natural (2014), WenJun (2012)
[21] All pictures in this thesis are taken by the author unless otherwise indicated.

over Toa at all hours. Evangelicals have strong bonds of solidarity and reciprocity with each other (ibid), bonds that traditionally was restricted to the *ayllu* (K- family, community). When asked why they converted many say they used to drink too much. Sobering up and becoming evangelical seems to be one and the same. "*Evangelicals don't drink*" was the first explanation given to me by both Catholics and Evangelicals when asked about the difference between the two religions. Evangelicals would also generally add that before they found God's true word people used to drink, fight and not care about working, sending their children to school or getting ahead. Many see the last decades' modernization and even the formation of the parish in 1980 as a direct result of the evangelization of Toa.

The parish of Toa was founded in 1980. Before that it had formally been a part of Shiricá (a pseudonym), but largely unrecognized. There were no paved roads and no electricity. People mainly produced for local consumption, and getting something from the city was both difficult and hazardous. One had to walk for hours on steep *chakiñans* (K-footpaths), and both robberies and rapes were frequent. Getting water also involved climbing down gorges, walking far with heavy metal barrels and constantly being in risk of robbery or rape. The houses were built from *kamkawa* with straw roofs and earth floors, and it was not uncommon to have guinea pigs (the most important domestic animal) running loose inside the houses.

Installing water tubes, paving and repairing roads has all been done on local initiative, but with some external funding. Edison, the health committee president told me that it had been a difficult struggle, and that the residents of Shiricá had been protesting when the Toas started building the first road up the mountains, almost 40 years ago. Many felt abandoned by the government, and told me no one had ever cared about providing Toa with water, electricity and roads. Anything they wanted they themselves had to make happen. Roads and water tanks are still being built or repaired on *mingas* (K- community work). As many young people migrate or have day jobs in the city, the work is carried out slowly by the elders. Even though many, if not most, young people migrate today, this feeling that they built their own community gives them a sense of pride and a wish to never completely sever the ties with their birthplace.

Methodology

The first month of my fieldwork, I was part of a U.S-based NGO working out of Riobamba. They offer language classes in medical Spanish to U.S. medicine students, and let them observe how medicine is practiced at hospitals and clinics in the area. Becoming friends with the medicine students I got to hear tales from a wide range of hospitals and clinics, which provided me with a good introduction to the medical world of Chimborazo. The first week the NGO placed me with the Toa health team, and the rest of the month I helped run health education camps for children in the communities. For an anthropology student looking for "a way in", it was perfect. We worked at schools in four different communities, and through the children I could observe how socio-economic status varied within Toa. A significant observation was how children in the middle and low communities tended to speak more Spanish and more often include education and city jobs in their hopes and plans for their future then the children in the two higher communities. The latter also had less engaged teachers, the classes were smaller, and the number of siblings per family larger. Helping out at the camps also made me feel a little bit less like an outsider when I came to live in the community. Whenever I felt lost at social events, it helped hearing my name being shouted and seeing small faces smiling, and several hands waving enthusiastically at me.

When my first month was over I stayed with my host family in Riobamba for two more weeks, and I kept in touch with them throughout my fieldwork. My host family was helpful and patient. I could ask about anything and they would always make an effort to answer. Although it was very comfortable living with them, it put limitations to my fieldwork, and I needed to get access to a rural community. I contacted the NGO again, and they offered me lodging at a tourist center in Toa. Here I quickly made friends with the employees who would not only guide me around telling stories and answering questions, but also helped me practice Kichwa, while I taught them English. I contacted the medical team in Toa, but as they only worked within walking distance once a week, it was not enough to fill my need for information. Therefore I decided to move yet again, and finally after almost three months I found myself living in a community. From there on I spent two to five days a week with the health team depending on transportation access. In the clinics I mostly sat in a corner with my note book, asking an occasional question, but rarely getting an answer. Sometimes the patients were friends and acquaintances, or I had the chance to talk to them before they went

in to see the doctor, but often I just sat quietly in a corner. The doctor tended to get annoyed when I delayed her work trying to introduce myself, and the patients never asked. I presume that this was not because they lacked curiosity but out of respect for the doctor, or perhaps because they were used to medical students coming and going. I felt uncomfortable not introducing myself properly, but whenever I did people did not seem to think it mattered much. Several patients explicitly told me not to waste my time introducing myself if I needed to be in there seeing what the doctor was doing. I was still uncomfortable with the situation and was extremely happy when I finally got the *auxiliares de enfermería* (nursing assistants, hereafter only *auxiliares*) to introduce me. That way, I did not disturb the doctor and, as I gradually learned, the introduction came from someone the patients already trusted.

By the end of October, María, one of the *auxiliares* started working again after a one month vacation. This was probably the best thing that happened to my field work. Not only did she consistently introduce me to the patients (the others frequently forgot), but on the days when the doctor was busy at other clinics she took me with her doing home visits. She was always willing to translate, and to answer questions regarding health, culture, migration, change, religion or whatever other subject I felt confused about. In return I helped carry her equipment, filled out vaccination cards and kept her company on the long walks. I also spent two days on the clinics with Marta, another *auxiliar*, and one morning alone with the male *auxiliar*, Segundo in the parish center. Since he was the oldest of the *auxiliares*, and had helped collecting information to a book on natural medicine in Toa[22] getting a chance to interview him was very valuable to my fieldwork.

During my time in the field the health team did several school visits and also three health brigades. Two of the brigades were held in remote communities as a way of reaching out to patients who otherwise would not seek medical attendance. These brigades were organized in collaboration with the medical team after an initiative from the local health committee. During fieldwork they also organized one large health fair in the parish center. In the communities I met health inspectors and a government employed team who drove around in a mobile health clinic checking up on school children and educating their parents about nutrition and hygiene. Towards the end of fieldwork, when I felt I understood the routine at the public clinics I visited the *Seguro Social Campesino* (peasants social insurance, hereafter

[22] The title of this book compromises the anonymity of my fieldsite. I refer to it by year (1992) but cannot include the full reference.

only *Seguro*) clinic looking for a comparison. I interviewed the doctor, and spent two days shadowing him and his dentist colleague, both at the clinic and doing home visits to disabled patients. I therefore feel secure that I have been able to observe the various aspects of health care in Toa.

The health team I was introduced to by the NGO, and whom I spent the most time with was employed by the *Ministerio de Salud Pública* (ministry of public health, hereafter MSP). They generally only worked until lunch hours, so my days with them, although numerous were short. Even so, I was never out of things to do. Living alone, a huge amount of my time was spent heating water for showering or washing dishes, doing my laundry, cooking or boiling water for safe consumption. Sometimes I missed the comfort of my previous accommodations but at the same time I appreciated the opportunity to internalize daily routines in Toa. Evenings and weekends were normally spent with my neighbors. They taught me how to cook, harvest, feed the animals, and they took advantage of my love for children when they needed a baby-sitter.

Finding a field method I was comfortable with was challenging. One of the first things I decided was that as far as possible I wanted to avoid doing interviews. I knew this would mean it would take me longer to get relevant information, but what I gained was information that was spontaneous, natural and given in a relaxed situation based on trust and friendship. Naturally I constantly asked questions, but hardly ever with a note book in hand. I suspected the stress about giving "the right" answers would not necessarily give me good answers. This was confirmed the few times I had my notebook and specified that I needed the information for my thesis.

The few formal interviews I conducted were with the coordinator of the NGO, the director of the Hospital Andino Alternativo, the *sobadora* (bone setter) at the same hospital, and with doctor Andrés at the *Seguro*. The rest of my information is based either on asking informal questions book in hand, friendly conversations, or participant and sometimes side line observations with or without my notebook. Conversations I was not directly a part of excluded me completely until the last couple of weeks when I finally started to understand some Kichwa[23]. This of course limited what kind of information I could get access to.

[23] This refers to Toa and was of course different among my contacts in the city where Spanish is the everyday language.

Challenges

One of my main challenges was getting contacts from different families. I soon realized that people's social world is centered on their extended family, and all contact outside family bonds is marked by gossip and mistrust. At the tourist center I got to know a girl of about my age who helped me find housing in Toa. I ended up living in her brother's house (he lived in Shiricá) and was quickly placed within their family. The entire extended family gave me a warmer welcome then I ever expected. Conversation with all of them, regardless of gender and age[24] flowed easily. This was unfortunately not the case with the rest of the community. Some were quick to weigh their words once they realized I was "affiliated" with that certain family. And "my" family was quick to judge if they observed me with someone else. Even with the limitations this put to my fieldwork it also turned out to be one of the greatest advantages. Through them I got to see village life from the inside. I learned what it meant to fill the role as mother, husband or sister, not only from the peoples' own perspective, but from that of their children, wives and brothers. In a family with seven grown children I could see the social differences of being single or married, a woman or a man, oldest or youngest, migrant or not, educated or uneducated, employed or unemployed. Of course one could always argue that one family can never be representative, but on the other hand, doing things differently would never have given me such a deep insight on their daily joys and worries. The people I met on the clinics, both personnel and patients, the ones who worked at the tourist center, parish officials, and the young man working at the local "internet" were all important informants. Having contacts outside "my" family and community provided me with an opportunity to get a good impression of how localized or universal a point of view or specific knowledge was.

Ethical concerns

Living and working in a small community, I collected information far surpassing what has been included in this thesis. Some of the information I have chosen to leave out is related to personal and family secrets, or touches upon sensitive matters. Nevertheless, this type of information has been very useful for me to make sure I have understood the Toas correctly, and it has also been a guideline to what is considered sensitive to them. In writing about

[24] There was some difficulties communicating with people over 40, but that was due to language barriers, not our effort.

delicate matters such as health, sickness, inequality and injustice it has been important for me to be aware that people may have very different views on what is considered sensitive than I do. I needed enough time to thoroughly learn about local culture to make sure I stayed within their boundaries of ethical censorship. Since I was fortunate enough to be an integral part of two families, first in Riobamba, then in Toa, people started opening up to me as a friend. It has therefore been important for me to take a step back, put myself in their position and try to decipher what information they would feel comfortable seeing in print.

Spending most of my time with one family in Riobamba and one in Toa has made anonymizing challenging. Both are extended families divided into several households (four in Riobamba and eight in Toa). To ensure anonymity I have chosen to not state age, marital status, who they live with, how many children they have etc. unless the analysis explicitly require it. Therefore I feel comfortable that it will be difficult to tie specific information to individual people. In writing about marginalization, I portray a tension between mestizos and indigenous people. I have tried my best to convey how this discrimination is inherent to Ecuadorian society and not a result of bad intentions from individuals.

The greatest ethical concern has been to protect the health care personnel in Toa. Since they are so few, anonymizing them has been challenging, and probably inadequate. This is the main reason for anonymizing the field site, as it would otherwise have been impossible to hide their identity. In outlining how the health workers are tied to a structurally unjust system, which gives little importance to rural, indigenous areas, I hope to have been able to present my critique as a criticism of national and regional politics and discourses and not of individuals. It should be remembered that good intentions are important although results might be bad. I hope research participants and readers will recognize *my* good intentions when I exemplify an unfair health care system through individual practitioners.

Methodology in writing

This thesis contains four thematically focused chapters centered on ethnographic cases, which combined with theory provides an analysis of how public health care work in Toa. All person's names, and most place names are pseudonyms to protect the people who have so generously shared their knowledge and lives with me. I have used names that were popular at my field site, but never corresponding to the actual people mentioned. To reflect the respect Ecuadorian doctors are shown, I have chosen to always use the title *doctor(a)* in front of their names. In the analysis and interpretation of my field data I have used the cultural knowledge I acquired through six months of field work, and another six months as an exchange student in Quito in 2010. My data is supported by a specter of anthropological work done on relating subjects or in the same region.

I wrote my field notes in Norwegian, Spanish, English and some Kichwa and I have therefore had to translate them and make some minor changes to increase readability. All translations are mine, and I do not exclude the possibility of errors. Mostly my research participants spoke Spanish, but Kichwa was consistently used for some words. In this thesis the reader will therefore find translations from both languages. I have chosen to mark translations from Kichwa with a "K" while I have left Spanish translations unmarked. Whenever written text has been translated it is indicated.

Unless my purpose is to point to highlight a specific contrast between "indigenous people" and "mestizos" I refer to the peasants of Toa as Toas or Kicwhas, names they themselves use. To quote anthropologist Sánchez-Parga:

> At first, for almost five centuries, they were named Indians, and then during the last decades, they have been called indigenous. Now they start calling themselves by their own name: shuar, saraguros, otavalos, cañaris, chibuleos… (…) If he now recognize himself not from the discourse of 'the other', but from his own [perspective] it is anthropology's task to participate in this recognition (Sánchez-Parga 2013:11, my translation)

Thesis layout

This thesis has four main chapters. I start out with a discussion on biomedicine, what it is, and how it is tied to Western culture and beliefs. The main focus however will be on demonstrating the form biomedicine takes in a rural Ecuadorian community. We will see that structural injustice and a history of normalized discrimination of indigenous people greatly affect health care today. In the third chapter I explore how the Toas conceptualize health, sickness and health care. The main focus is on traditional Andean beliefs and practices and how these play out in the community today. From these two chapters it should be clear to the reader that biomedical doctors and indigenous patients have largely conflicting understandings of what good health care is. Furthermore, there are often great disparities between Andean and biomedical etiologies and since "[W]hat counts as therapy depends first on what is defined as a problem" (Csordas and Kleinman in McKee 2003:138) tensions arise. In chapter 4 the discussion moves on to how these tensions get magnified in a culture where marginalization, abuse of power and social hierarchies are largely normalized. In the final chapter we see how the *auxiliares* manage to navigate local conceptualizations and biomedical practices in a way that enhances trust in biomedicine. I argue that the *auxiliares* play a vital and largely unrecognized role in biomedical health services at rural clinics.

Chapter 2

Biomedicine in a rural context

Introduction

In this chapter I will present the Ecuadorian health care system and discuss how it is a system that has prioritized the urban and relatively well-off population. Although recent restructurings (MAIS 2012) are intended to make the system fairer, the urban and the wealthy are still the winners in Ecuadorian health care. In this chapter I will explain how health care is organized in Toa and Riobamba. I argue that rural health care is not only inadequate to serve patients' need, but is equally unattractive as a place of employment. This leads to a high level of frustration for both personnel and patients. But before I start looking into the local practice of biomedicine, it is important to understand what separates this approach to medicine from other medicines.

Choosing a terminology

When describing the official health care system I need a term that separates this way of healing from traditional, or indigenous, healing systems. In Western societies this medical system is often simply called "medicine" as it has enjoyed a "virtual medical monopoly" (Hahn and Kleinman 1983:314), (in developed countries) for the last century. However a more descriptive term is needed, both to separate this medical system from other "medicines" and to avoid assumptions that one medical system is more efficient than another. Official health care in Ecuador is based on a system of practices and beliefs that has often been referred to as western, modern, scientific or allopathic. I find the term biomedicine to be useful as it highlights that this medical system is based on biological and scientific

knowledge, rather than religious or spiritual knowledge[25]. Biomedicine is also the term chosen in several introductory books on medical anthropology (see e.g. Ingstad 2007, Singer and Baer 2012), and over the last decades biomedicine has become the most common term within the field (Singer and Baer 2012:120). I follow Hahn and Kleinman in choosing the term biomedicine because it refers to "its primary focus on human biology, or more accurately, on physiology, even pathophysiology" (Hahn and Kleinman 1983:306). At the same time they recognize that other medicines, such as contemporary Chinese, has a similar focus and thus biomedicine "is the version of bio-medicine founded and dominant in Euro-American societies and spread widely elsewhere" (ibid).

Placing biomedicine within a knowledge system

Although alternative medicines increasingly gain popularity outside the cultures they sprung from (as with for example acupuncture and homeopathy in Norway) many still see these healing traditions as superstition, while biomedicine is largely accepted as truth. Disputing its effectiveness is in a way to challenge science itself. Furthermore, as biomedicine often is the only state-supported medical system it retains its hegemonic position. Even within anthropology biomedicine has often been viewed as *the* medical system and not *a* medical system. (Singer and Baer 1995:17). In 1988 Kapferer suggested that "medical anthropology is itself hegemonic. It incorporates Western ideological medical assumptions in the routine of its practice" (1988:429). Increasingly, however, anthropologists have begun to treat biomedicine as any other ethnomedicine, although its uniqueness is also recognized (Hahn and Kleinman 1983, Singer and Baer 2012)

Although universal in its outreach, biomedicine is not universal in its practice. Lynn Payer (1988 in Singer and Baer 2012:118f) compared biomedical practices in four Western countries (France, Britain, Germany and the United States) and found great variations. For example, German physicians were "much less likely to prescribe antibiotics than U.S. physicians" (ibid 119). Difference in practice between Western countries and Latin American countries is probably even larger. Further, biomedicine also takes very distinct forms *within* a society. Hahn and Kleinman points to the fact that biomedicine with all its subfields and specializations is not one but many medicines (1983). General medicine, pediatrics,

[25] For a further discussion about the term biomedicine see e.g Hahn and Kleinman (1983) and Ingstad (2009).

dermatology and brain surgery are all very different practices and skills within the biomedical domain. For the purpose of this thesis, however, there is no space to closely examine the variations within biomedicine, and it will be treated as one (ethno)medical system, contrasted to other systems, such as Andean medicine.

What characterizes biomedicine from an anthropological perspective? Firstly it is largely separated from religion, moral and politics (Hahn and Kleinman 1983), at least in its ideals. These ideals of being independent and based on objective truth (science) make biomedicine distinct from many other medical models. But as Barth (2002) has reminded us, academic knowledge (and by extension Western science) is not context-free, although it is often portrayed that way. This means that contrary to its ideals biomedicine in its practice is influenced by states and individual doctors' religious, political and moral views. An example is the Norwegian debate on whether or not general physicians should be allowed to reserve themselves against referring women to gynecologists for abortions[26], and ongoing debates on biotechnology. It has also been argued by many that biomedicine, and especially the pharmaceutical industry, supports capitalist ideals (see e.g. Price 1989, Gartin, Brewis et al. 2010, Seeberg 2012). In other words "[h]ealth is being commoditized" (Marsland and Prince 2012:459). Further the "central concern of Biomedicine is not general well-being, nor individual persons, nor simply their bodies, but their bodies in disease" (Hahn and Kleinman 1983:312)."Disease" being the sickness as defined and diagnosed by a physician, and contrasted to the patients lived experience of "illness". Social and personal factors have little, if any room within biomedicine where sickness and healing is always rooted in something natural (biological) or scientific (ibid: 313). "Michel Foucault argued in *The Birth of the Clinic* (1975) that biomedicine emerged around 1800 in Europe as it systematically began to classify diseases into families and species and focused more on the body (…) than on the ill person" (in Singer and Baer 2012:132). Even listening to the patient is detached from social relations but construed as a form of gaining access to diagnostic history (Hahn 1982 in Hahn and Kleinman 1983), what Fox has described as "detached concern" (1979 in Hahn and Kleinman 1983). Many physicians detach from patients as persons to handle their jobs by referring to them as body parts or engaging in gallows humor (Hahn and Kleinman 1983, Singer and Baer 2012). We cannot assume that just because biomedicine is universal in its outreach it takes on forms devoid of cultural associations, values and meanings. A strong tie

[26] See e.g. Mikkelsen (2014) in *Verdens Gang*

to Western cultural ideals is the strict authoritarian hierarchies and focus on professionalism within biomedicine:

> physicians generally enjoy prestige, high incomes, relative autonomy over work, and a monopoly over the prescribing of dangerous drugs, declaring people mentally incompetent, signing birth and death certificates, and referring patients to other health practitioners (Singer and Baer 2012:133).

The hierarchical form of biomedicine is especially prominent in the Ecuadorian context, where social inequalities are naturalized on almost all arenas. Having a dominant medical system, which allows these social inequalities to play out in their fullest forms, is problematic for "low status" patients. It can also be a stressing factor for doctors who do not enjoy the level of prestige and respect they are educated and socialized to expect. The rest of this chapter will explore the difficulties in rural health care, both for the doctor, and her patients. I focus on practical difficulties such as long distances, lack of equipment and the harsh climate, while difficulties regarding social relations will be discussed in chapter 4.

How Ecuadorian health care is structured

Mainland Ecuador is divided into three regions: *costa* (the coast), *sierra* (the highlands) and *oriente* (the orient/Amazonia). The three regions largely have developed separately, and my knowledge of (the medical world of) Ecuador is limited to the highlands. Highland Ecuador is divided into provinces, cantons and parishes. My fieldsite Toa pertains to the canton of Riobamba, which is also the province capital of Chimborazo. This means that compared to other rural parishes, Toa is fairly close to a large urban center with well-developed health care. But as we saw in the introductory chapter, even though distances may not be great, social barriers are enormous, and only a generation ago contact between Toa and Riobamba was extremely limited. At the time of fieldwork, the distance still felt long for many. Only those who had cars could easily get to the city, others relied on their neighbors or the infrequent and overfilled buses. The doctor stressed to all pregnant women that they could call her in case of emergency and she would send an ambulance. In reality, however, this was often not possible, as even those who had cell phones rarely had enough credit to make a call. For many looking down at the city lights is not safety but a reminder of their own marginalization.

Puestos de salud, Subcentros and Hospital

In this section I wish to give a description of the professional sector in Ecuadorian health care. Except for the Hospital Andino[27], this sector works exclusively with biomedicine. There have been great divides between the private and public sectors, but with the implementation of a new law (MAIS) in 2012, any hospital is required to offer their patients all services, and they can thus be transferred from public to private hospitals without any extra costs. The ethnographic material is taken from Toa and Riobamba, focusing on a rural context but supplemented with some urban examples.

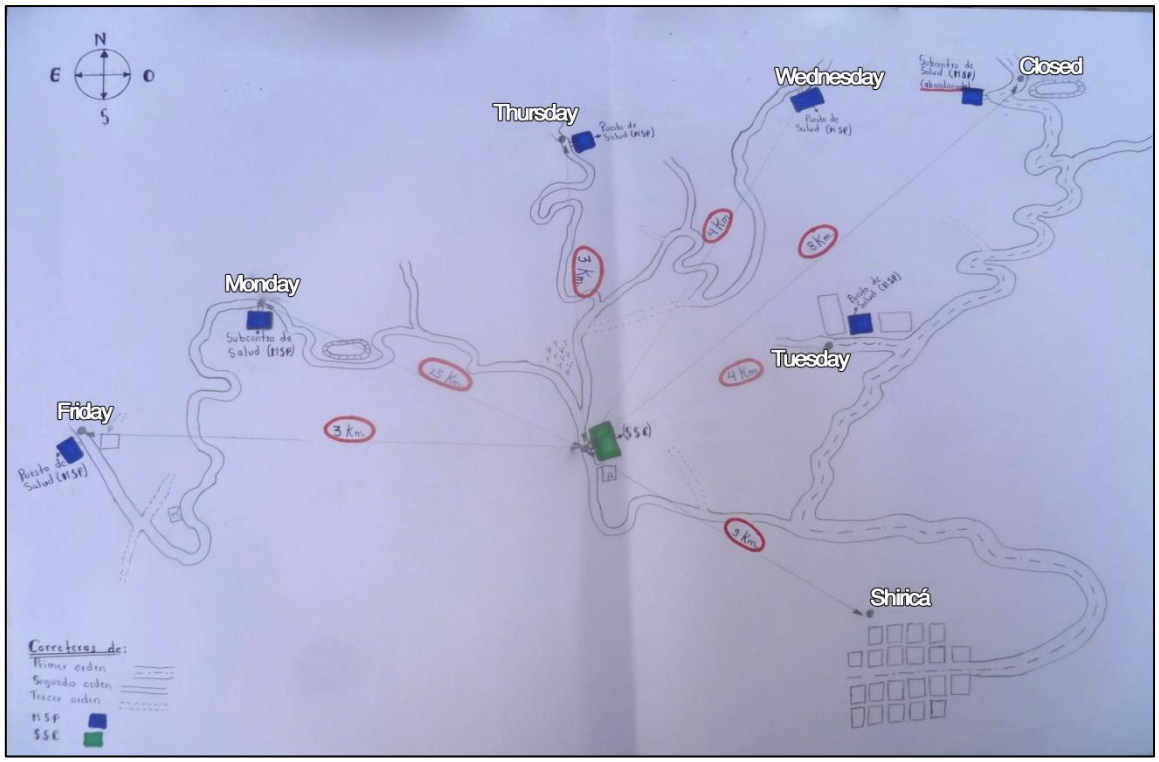
In Riobamba there are two public hospitals where the patients do not pay for services or medicines, and four private hospitals.[28] The *Instituto Ecuatoriano de Seguro Social* (the Ecuadorian Institute of Social Insurance, hereafter IESS) is operated by a private insurance company, but anyone who is permanently employed is affiliated[29]. This means that many have access to free health care at the IESS, which makes it similar to a public hospital. The private hospitals are generally known to be of higher quality than public ones. There are also innumerous private clinics, as anyone with a medical title is free to open one. Unless it was an emergency or one had scheduled a check-up at the hospital, one needed to pass by a local clinic called sub-center (*subcentro)* or a smaller health post (*puesto de salud*) to get a referral. This works similarly to the "fastlege" system in Norway; a system were one doctor is responsible for a certain area/number of people and judge which cases are serious enough to need transfer, and which patients can be cured on the spot. Rural areas were generally served by health posts, and patients got transferred to larger *subcentros,* or if needed hospitals, in the city if the health post lacked equipment to perform certain tests or treatments.

[27] The Hospital Andino is introduced properly in chapter 3. It is a hospital that combines biomedicine with traditional and alternative medicine

[28] Public *Hospital General Docente* (the general hospital) and the *Hospital pediátrico Alfonso Villagomez* (the pediatric hospital). Private: Hospital Andino Alternativo de Chimborazo, San Juan, Hospital de Brigada Galapagos (military hospital) and the social insurance hospital,).

[29] Most employees pay half the insurance for their employers, and cut the other half directly from their salary. Thus anyone who receives an official pay check is automatically insured.

Official health care in Toa



Illustration[30]: The sketch shows all the health posts in Toa, the green one is operated by the *Seguro Social Campesino*. The *Minesterio de Salud Pública* (MSP) operates five (blue) clinics. (The sixth one has been abandoned for at least six years). I have chosen to name the MSP-clinics by the weekdays they were served by the full medical team.

In Toa there are currently two health teams operating six clinics situated in 6 of the 23 communities. The clinics were officially labeled dispensaries, *subcentros*, or health posts according to what services they could offer. However, differences were minor, and to avoid unnecessary confusion, I call them all "clinics" in this thesis. One health team is employed by the *Seguro Social Campesino* (Peasants' Social Insurance, hereafter *Seguro*), a branch of the IESS insurance company that specializes in peasants' health. The affiliated peasants pay 1,79USD per month and their whole household get access to health care at the local clinic, free medicines and transfer to the large *Seguro* hospital (IESS) in Riobamba. About 80 % of Toa's population is affiliated according to the *Seguro* doctor. The clinic treats an average of 12 patients per day, three days a week. Andrés the *Seguro* doctor was passionate about his

[30] Reprinted with permission from the drawer (doctor Andrés at the Seguro clinic).

work, with a master's degree in public health and a genuine wish to help people. Having worked many years in various indigenous communities he spoke enough Kichwa to communicate when the patients were uncomfortable in Spanish. However he felt that people did not appreciate the services they got at the clinic. Both he and the dentist worked part-time at private clinics, where they had access to better equipment, and made more money than they did working in Toa. After the reorganization of Ecuadorian health care, a consequence of the MAIS-law (2012), doctors were forced to spend full workdays at their primary place of employment. Many doctors chose their own clinics, and it is said that the IESS hospital lost their best staff as a direct consequence of the restructurings. That *doctor* Andrés and Juan (the dentist) chose to stay in Toa and only work a few hours in the afternoon at their better paid clinics is a strong indication of their motivation to work with rural health.

The other five clinics were operated by the *Ministerio de Salud Publica* (Ministry of Public Health, hereafter MSP), and are the ones I know the best. This was the first time a doctor was employed on a four year contract. Usually the clinics were operated by *rurales*, recent graduates who spend one year practicing medicine in remote areas before they are allowed to freely apply for jobs. Because of the system with the *rurales* at times there is one doctor per clinic in Toa, but at the time of fieldwork *doctora* Andrea alone was responsible for all five. The MSP health team consisted of one doctor, a dentist, a nurse, three TAP[31] (*Technicos de Atención Primaria de Salud*, technicians in primary health care) students and three *auxiliares de enfermería* (nursing assistants, hereafter referred to as *auxiliares*). The doctor and dentist were government employed, randomly placed to work in Toa, and not shy to express how difficult this was for them. Their complaints are not altogether unfounded. The clinics are poorly equipped which makes even general checkups difficult. It is only one doctor and one dentist to cover all five clinics meaning they need to rotate; spending one day at each clinic, regardless of patient distribution. The MSP also expects them to visit all of the schools and kindergartens to check for malnutrition and other common ailments, while doing home visits taking tuberculosis tests, giving medicines against parasites and educating people about safe water storage and treatment. There are computers at the clinics, but patient files are not digitalized. Papers frequently get lost, and at the end of each month there is the time consuming task of finding, sorting and digitalizing a month's worth of medical data.

[31] I will describe who they are and what they do later in this chapter.

Recently *doctora* Andrea only operated the two largest and most accessible clinics which gave her time to visit schools and kindergartens, while now she said she hardly had time to see the patients who showed up. She talked about a project were they are going to build a mini-hospital in the parish center and consequently shut down all the smaller clinics. She told me that at first patients will not show up, but as "*they learn*", it will get better. The change will unquestionably make it easier for the doctor and will increase the amount of services offered to include small surgeries etc., but it will also involve a 2-3 hour walk up and down the steep hills, each way, for the ill and elderly.

There are three *auxiliares* who work with *doctora* Andrea in Toa: Segundo, María and Marta. The *auxiliares* had received some basic biomedical training after only seven years of primary school, but they had taken some extra courses e.g. in vaccination, in addition to finishing high school while they were working. Segundo, the oldest of them, has never gone to conventional school, but taken evening classes to learn the basics, and graduated from high school through a long distance program. All of them had worked in the community since the first health clinic was opened in 1984. Segundo is responsible for the Tuesday clinic, which is the largest of the five and located in the parish center. After the sixth clinic was closed, all the higher communities on the right side of the first crossroads pertain to the Tuesday clinic. This clinic therefore receives many patients, and Segundo has to cover a large area when doing home visits. He owns a car which facilitates this. María manages the Monday and Friday clinics. The Monday clinic is located in a middle community and is the second busiest clinic. The Friday clinic is in a poor lower community and is not visited by as many patients. Marta is in charge of the Wednesday and Thursday clinics which are both located in higher communities. Because of the geographical and demographic situation[32] the patients in these clinics are more likely to be elderly and monolingual than patients at the other three clinics. They also receive few patients (as low as 5 a day). Marta has a car, which makes it easier to reach most remote clinics. The *auxiliares* walk around in the communities talking to everyone. They visit houses were patients are recovering from an operation, or someone is rumored to be sick. They know where the pregnant women, the disabled and the elderly live, and make regular visits to check up on them, remind them to see the doctor if something is wrong, and answer any questions they might have. The *auxiliares* also takes phlegm tests for tuberculosis, and hand out medicine to those families affected (only one at the time of fieldwork). They administer

[32] Higher communities are far from the city and generally windblown. They see a higher level of migration than the other communities, although migration numbers are high throughout Toa. Note abandoned houses in the picture at page 37

vaccinations and other injections. The *auxiliares* are the ones who have the most complete overview of the health situation in their communities and they are known and trusted by everyone.

About halfway through my field work a nurse, Cristina, who was doing a year of provincial service (*rural)* started working at the clinics, taking some of the work off both the doctor's and the *auxiliares*' hands. On her first workday I asked her if she had been free to choose Toa as the site for her period as *rural*, and if so why she chose it. Cristina answered that since she was unmarried and did not have children she was not a prioritized group and her choices had been limited. She had preferred Toa, among her choices as she did not have to live in a community but could live in Shiricá, close to Riobamba. After around three weeks she expressed that she was very frustrated with her work situation. She had not expected Toa to be so cold, and she was unprepared for the lack of transportation and tired of never having somewhere to eat lunch[33]. Bastien (1987) describes the same frustration among Bolivian doctors. He says that many see their year as *rurales* as a waste of time until they can get urban work.

> Others try to serve the peasants but become frustrated because of the lack of communication and utilization of their services. They become discouraged when peasants refuse to accept vaccinations, therapy, and hygiene. Doctors interpret this as ignorance and resistance to change (Bastien 1987:1110)

The last actors working with health in Toa were the TAP-students. They were three locals studying to become *técnicos de atención primaria de salud* (technicians in primary health care). They were part time in classes, part time at the clinics and sometimes they had their own activities in the communities. When done studying they would be employed locally and have responsibilities somewhere between that of an *auxiliar* and a nurse. During my fieldwork they went from house to house getting a general overview of the health situation; they planted vegetable gardens for families with children under five with nutritional deficiencies, for pregnant women and for disabled. However, not everyone wanted the gardens, and not everyone took care of them. Similar projects had been carried out earlier, but none had succeeded: "*Why plant broccoli that is foreign to us when we have plenty of*

[33] In Ecuador it is expected to have an hour where one can either go home for a warm meal, or eat a full, often three course lunch at a restaurant. In Toa, only the Tuesday clinic was fairly close to a restaurant.

potatoes?" was the general attitude in Toa. The TAPs also spent time at the clinics assisting the doctor, finding papers and equipment or translating when necessary.

Medicine students from the United States were also sporadically present at the clinics. They were affiliated with the same NGO as I was, working out of Riobamba, and were there to learn about how medicine is practiced in Ecuador. They spent mornings before lunch at the clinics, and had Spanish classes two hours in the afternoons. The weeks when students were at the clinics, the health team was guaranteed transportation in the mornings and if they wanted, they could also hitch a ride back down at noon. The *auxiliares* generally stayed even if the others left since they did not depend on transportation to the city.

Everyday practice at the Ministry for Public Health's (MSP) clinics

Entering the Toa clinics it is striking how little privacy there is. The first thing I reacted to was how all the clinics had hand drawn maps of the communities; here you could see which houses were abandoned, how many people lived in each house, which houses where in socio-economic, biomedical risk (chronically ill or potentially contagious, e.g. cases of tuberculosis), or especially vulnerable people (elderly people living alone, or people with disabilities). Houses marked with sanitary risk meant that that the house was particularly dirty or filled with garbage. This was not always a lack of care (as implied) but could happen if people worked in recycling, or in one case a river brought litter almost to the family's front door. The maps were displayed either in the waiting room or the doctor's office, but were always in plain view for all the patients to see. Each clinic also had a "situational board" which showed various statistics, such as how many pregnant women lived in a community or how many vaccines had been administered. They were there for the personnel's benefit but hung in public as there was nowhere else to put them. The door between the waiting room and where the *auxiliares* and nurse worked was always open, and only talking to the doctor could be done in private.

Picture: This illustration shows part of a map displayed in the waiting room of the "Friday" clinic. It marks which houses are in biomedical risk (green), sanitary risk (yellow), socio-economic risk (blue), or where vulnerable persons live (purple). As the reader will notice, almost all the houses are marked with sanitary and socio-economic risk. Houses marked with an "A" are abandoned, pointing to the high migration rates in the area.

In one case, a teenage patient came in with extreme stomach pain and the doctor asked us all[34] to leave. When I later inquired about what had happened the next patient was shown in before she got a chance to answer, and it ended with the doctor giving a long speech on doctor patient confidentiality and professionalism. This surprised me as I had never seen any signs of privacy being valued before that day, but it was of course not a subject I wanted to argue about. At the end of the day I asked again and the doctor answered that the symptoms could point to pregnancy, abortion or a sexually transmitted disease, and asked if I would have liked that information to be public. She said she preferred to keep the information confidential, and that I would not understand anyway since I was not a student of medicine. Although I was curious I decided that the doctor prioritized to keep her patients' secrets over providing me with information was a good thing. Later however, the doctor and dentist started listing up the names of all the pregnant women in the community in front of another patient. Women in Toa generally kept their pregnancies secret until it showed and it surprised me how the discretion

[34] That day there were two U.S medicine students, two TAPs and I present.

shown to the young girl was not extended to these women. At the clinics it was the doctor, not the patients, who were in a position to define privacy. How power-relations influence the social interaction at the clinics will be further discussed in chapter 4.

Relationships between colleagues

The doctor and the dentist saw themselves as equals and friends. Even so they always spoke to each other using the title *doctorita*[35] instead of their personal names. When the nurse started working there she was shown the same respect, always being referred to as *lice*, short for *licenciada*. With the TAPs (technicians in primary care) the relationship was more complicated. The doctor often did not know if they were going to show up or not, and the TAPs frequently had their own tasks. The doctor could ask them to do things, and they asked her permission if they wanted to go visit the communities. I never witnessed any conflicts between the TAPs and any of the other staff, and when one of them was kicked out of the program because he failed a written exam, the doctor did everything she could to get him back in. The TAPs always treated the doctor respectfully, and spoke in low voices around her. The fact that they never challenged her authority could of course be an essential part of why they got along.

The relationship between the doctor and the *auxiliares* was tense. Discussions and conflicts between the doctor and the *auxiliares* were relatively frequent. While the dentist always treated them respectfully, she would stay quiet in a discussion and never argue against the doctor when conflict arose. Part of the tension came from difficulties in finding a social position they could all agree on. The three auxiliaries had worked in the community for almost 30 years, and they were older that the doctor. When she was not present, the *auxiliares* were in charge of one or two clinics each. That meant that they, better than anyone, knew the place, the equipment and the patients. This knowledge was most frequently mentioned by the doctor when something was missing. The *auxiliares* were afraid to speak against her and were never listened to, something that increased the level of conflict between them, as the following case illustrates.

[35] As mentioned the suffix –ita when used in this context connotes professional respect and social distance rather than fondness and familiarity. When using a doctor's first name, it should always be preceded by professional title. As the reader have already noted, I have chosen to keep this respectful practice throughout the thesis.

In the beginning of October 2013 doctora Andrea sent the nurse, Cristina and one of the auxiliares, Marta to a meeting with the area directors from the Ministry of Public Health (MSP). Marta was responsible for making digital charts on home visits and phlegm tests among other things for the months January through August since Cristina did not start until September. At a staff meeting the 9th of October Cristina brought up how difficult it had been to do the presentation at the larger meeting in Riobamba. Marta had been very late in sending her the information, and she had therefore not gotten sufficient time to prepare herself. The auxiliar never got a chance to defend herself, and the discussion turned into a larger argument where the doctor accused Marta of never answering the phone and having lost or misplaced instruments and papers.

Towards the end of my fieldwork I found an opportunity to ask Marta about the argument. She explained that she did not know how to use a computer, but the doctor did not listen and demanded she made the diagrams anyway. She had asked her nephews for help, and needed to wait for them to have the time to assist her, which was the reason for the delay. She also told me that she was frequently blamed for having lost equipment, and pointed to the above mentioned argument where the doctor had also said she would probably find the missing stethoscope in Marta's car someday. Further, she was also tired of being scolded at a weekly basis for never reading e-mails, and asked me to help her set up an account and teach her how to use it.

A harsh working environment

Doctora Andrea was in her late 30s, and came from a province in the far south of the country. She was intelligent and boasted that she found school useless and had managed to take the same medical exam as everyone else without ever going to class. Although she refused to speak other languages than Spanish, she understood Kichwa and English. When she could not find urban (or private) employment, she ended up working for the MSP who placed her in Toa. It was far from an ideal working situation. The clinics were extremely poorly equipped and often lacked simple instruments such as sutures. The spatial division was inadequate with people constantly moving between rooms and crowding the small spaces. Since public transportation was rare the doctor and dentist had to rely on private *camionetas* (pick-up trucks). Sitting crammed on the back of a truck is cold, uncomfortable, dirty and unsafe. Only a few *camionetas* had plastic coverings shielding its passengers from wind and dust, and even

fewer were equipped with benches. Often the pick-ups were over-filled so the last passengers had to sit on the railings. The drivers drove very fast, and the road had several sharp turns and large holes. Long stretches of the road were shouldered by high cliffs where *kamkawa* (K – hard soil) can fall down on one side, and there was an unsecured drop of up to 50 meters on the other side. Car accidents involving one or several cars are frequent. My impression was that everyone who lived in Toa had been in several accidents and they had all at some point fallen off the back of a truck.

As mentioned, the doctor had to rotate between five clinics and often papers or instruments had been forgotten the day before and thus were inaccessible. All patients' files were stacked in folders and sorted into risk groups (pregnant women, chronically ill, children, elderly etc.). When a child changed from kindergarten to primary school and then high school they often could not find the folders as they were categorized in the wrong place, or left behind at another clinic[36]. This also happened when women married and moved to their husbands' communities[37]. Once a month the data had to be organized, digitalized and sent to the Ministry of Public Health. This work took at least one day per clinic, and sometimes more than a week was spent stressing over paperwork. Every moment the doctor was not seeing patients fueled rumors that she did not work (hard enough).

Ecuadorians never bring their own lunch, and since only the "Tuesday" clinic lay close to a restaurant four days a week the only food available was chocolate, crackers and potato chips. In addition to being hungry, the doctor and her team were also chronically cold. In high altitudes temperature varies from freezing at night, to almost 30ºC in the mid-day sun. Inside the brick buildings, temperatures remained low, and the concrete floors chilled the feet. If there were few patients and the doctor had to go out and "look for them" it was always too hot (if sunny) or too cold (if windy and rainy). High altitudes, guard dogs[38], dust and mud also made walking uncomfortable.

[36] Often the kindergarten, school and high school would be located in separate communities so the child would belong to new clinics as they advanced through the school system.
[37] Toa is patrilocal. New couples generally live with the husband's parents until they can build their own house, normally in close proximity to the parents.
[38] Every household had several guard dogs, mostly running free. Some were given chili peppers to become particularly fierce.

Dealing with accusation

The doctor and the dentist frequently had to defend themselves against patients' accusations. Some were reasonable, others sprung from misunderstandings, and yet others must have been experienced as completely unfair. In this section I want to go through some of the most common or most severe accusations.

"A woman died of cancer because of the dentist"

According to a previous parish leader in Toa, the peasants (*campesinos*) believe all illnesses are a result of something or someone happening to them. They do not share the biomedical notion that a disease can occur suddenly in a healthy patient without some external catalyst[39]. During fieldwork a woman died from cancer, and the theories of how she got ill re-emerged. The main explanation was that a mistake from the dentist had caused the cancer. While the doctor frequently used this as an example of how difficult it was to work in Toa, the dentist herself did not like to talk about it. Towards the end of my fieldwork I found an opportunity to ask what had really happened. She explained that the patient had come in with a tumor in her jaw, insisting it was the tooth that hurt. The dentist had tried to explain that the pain did not originate from the bad tooth, but in the end had succumbed to the patients wish, and pulled it. The tumor which had been pushing against the tooth now had free range to push upwards and had become visible. The patient, along with the rest of the community concluded that the dentist had done something wrong and caused the cancer. They never accepted any other explanations.

"The doctor never works"

This statement was frequent, and it was true that *doctora* Andrea was not always available for consultation. Often the doctor would go home at lunch hours as there usually were no more patients after 1pm. But this had explanations. Sometimes the doctor had meetings in the afternoons, or needed to pass by a hospital with transfer papers for her patients. She also had mandatory classes each Thursday to expand her knowledge on how to practice biomedicine and run the clinics. During fieldwork there was a six-week period where the "Friday" clinic never opened, because *doctora* Andrea had court meetings, or was otherwise occupied. Three

[39] In book from 1992 which as previously mentioned cannot be sited.

years ago a 6-year-old girl from the community had been raped by her teacher. The teacher had been indigenous (which was rare), and according to the dentist the whole community had taken his side. "*You know how it is when the mother is young and unmarried*," the dentist said. The family wanted to keep it quiet but almost by chance the doctor had found out, examined the girl, concluded it was rape and reported it. The trials were still in process and since she was a key witness she often had to meet in court. Sometimes the court sessions were cancelled or postponed, but she still missed work. Further the doctor had to do general checkups on all the children at schools and kindergartens. Often on such days, she picked up her equipment from the main clinic and went straight to the school in question, thus leaving the clinic closed. Her absence from the clinic nourished accusations that she was not working, even though she was in fact working elsewhere in the community.

Another time a whole high school (about 25 students) came to the "Tuesday" clinic and the doctor and dentist decided that to treat them all they had to rush through patients, and fill out the paper work afterwards. After the students had left and we were having lunch, a woman came in with a toothache. The dentist told her that she unfortunately did not have time. Now she was on her lunch break, then she had to do paperwork. "*You have to come back next Tuesday, oh wait, we will be at school x. I'm sorry, but you have to come back in two weeks*." At a wedding the following weekend a man brought it up. "*A tooth hurts when it hurts*" he said, "*by the time she has waited two weeks she is dead from pain!"* I defended the dentist, saying she *did* have a lot of paperwork - it was not just an excuse to have a longer lunch break and go home. Although the fact was, when lunch was over, around 2pm, an opportunity for transportation presented itself and she decided to do the paperwork some other time. However, when she refused the patient, her intention had been to finish all the paperwork.

"The doctor is a bad person"

The Toas tended to portray *doctora* Andrea as a cold and heartless *bruja* (bitch)[40]. In the words of María, the *auxiliar*: "*She is very egoistic. And the patients are afraid of her. She always raises her voice at them (grita), scolds them (*habla*) for this or that*". Andrea was a very smart woman, and she was in no way oblivious to what was being said about her. "*But someone has to be the bitch*," she said, "*if that is what I have to be to get things done, then so*

[40] The literal translation of the Spanish word *bruja* is witch, but in this case it meant a bad, mean person, a bitch. People also used *bruja* in its literal sense, but only if they referred to people that had supernatural powers.

be it." She believed biomedical health care to be the best option for her patients, and would do anything necessary to get them to show up at the clinics. She could be more useful as a doctor and get to see more patients if they came to her, and did not want to spend time looking for them. She always did the days paperwork in the afternoons and everything was done by the next time she came to work. Therefore she wanted the patients to come early so she did not have to sit idle and wait for them. *Doctora* Andrea also said that frequent complaints, such as stomachaches, could be prevented if people had better hygiene, and boiled their water. The risk of tuberculosis would also be diminished by better hygienic practices. She felt obliged to tell them until they listened, even if they did not like to hear it. Her professional care surpassed a personal need to be liked. Unfortunately, she would probably have been more successful if her patients *did* like her. As María mentioned, many patients did not want to come back after they had been scolded by the doctor, for example for not having arrived at a certain time. It was also a common sentiment that she was too quick with her patients and only gave out medicines. Her effort to be efficient was interpreted as lack of care or interest. Being present at the clinics over an extended time period I was familiarized with the often conflicting views of the doctor and her patients. It became clear to me that the way Ecuadorian health care is organized prioritizes the urban population, and provides a better work environment for urban doctors. Health care in Toa was frustrating for all parties involved. But as one of the U.S medicine students said. "*There are different ways to handle a bad situation*". In her opinion, the doctor unnecessarily scolded and discriminated against her patients. This problematic will be fully elaborated on in chapter 4.

Concluding remarks

In this chapter I have presented official health care in Toa. Rural areas have never been prioritized in Ecuador, and Toa is no exception. The first health clinic opened in 1984, but *doctora* Andrea is the first doctor to gain a three-year contract. Before her, the clinics were manned by *rurales*, recent graduates who do a mandatory year of rural service before they are allowed to apply for jobs. The patients have limited access to health care as the doctor needs to rotate between five clinics, and often leave at lunch hours. The only biomedical alternative to the public clinics are the *Seguro* clinic, which opens no more than three days a week. Toa stretches over a vast geographical area, and steep hills and gorges make the walk to the clinics long and tiring for the sick and elderly.

It is important not to downplay the difficulties the health personnel encounter. Toa is far from an ideal work place. The clinics are poorly equipped, transportation is rare, the climate harsh and access to food limited. Further the health team encounters difficulties with mistrusting patients who speak poor Spanish and conceptualize health and sickness differently from the biomedical model. The first doctor to ever work in Toa wrote that the patients always wanted to know which *aguita* (tea) to swallow their medicines with. In the next chapter I will introduce traditional Andean medicine and explain the Toas' conceptualizations of health and sickness.

Chapter 3

Conceptualizations of health, sickness and healing in the Andes

Introduction

In the previous chapter the various levels of, and challenges related to, public health care system were explored. In this chapter the focus will shift to Andean medicine, and local ways of thinking about health and sickness. Barth has argued that the Balinese use Bali-Hunduism to "interpret and act on the world" (Barth 2002:8). In a similar fashion I would like to suggest that the Toas knowledge of Andean medicine influence the way they interpret and act with regards to biomedicine. Since biomedical health care was not available in Toa until the mid-1980s, it is important to explain the system Andeans have developed to deal with various ailments. It is important to keep in mind that there is a high degree of pluralism in medical belief and practice in the Andes, and many people do not see clear cut distinctions. A private hospital in Riobamba (Hospital Andino) combines biomedicine with Andean and alternative, orient-influenced medicine. The three medical traditions are said to be equal, but at the same time the hospital director argued that "*Andean and alternative medicines are complementary to the chemical. They are preventive, not curative. They help the patient get well quicker or a massage can help de-stress a patient before an operation*." Complementary is not the same as equally important. It seemed clear to me that she had most faith in occidental medicine as curative, but she acknowledged culture bound syndromes such as *espanto* (*susto*) (fright illness) and *mal aire* (evil winds), and that they can only be cured by a traditional healer. She did not seem to think that these illnesses were a part of indigenous culture specifically but part of their common ancestry as Ecuadorians. *"You probably don't have these illnesses in your country?"* she asked me laughingly. *"It is in* our *culture to believe in these things."* I found it very interesting that a mestizo woman would talk about a common Ecuadorian history and culture, and acknowledge supernatural illnesses such as *mal aire* (evil wind). At the same

time, this is precisely what medical pluralism is. In Toa, people sought treatment in prayer, plants, pills and surgery. They utilized the skill of mothers, neighbors, specialists and doctors. The previous chapter presented biomedical health care in Toa, this one will focus on the alternatives, often seen by the patients as complementary.

Religion in sickness and healing

Both urban catholic mestizos and rural evangelical Kichwas frequently viewed sickness as God's punishment. According to Elsa, my mestiza host mother in Riobamba, God punished doctors who performed abortions (illegal by both national and divine law) and told me about two specific cases. In the first case the doctor had gotten a sickness that made his hands useless. They were immovable and painful, a description fitting arthritis or other rheumatic diseases. "*And God did this*?" I asked. "*Well, what do you think? He used his hands to commit a crime against God's law, and now he cannot use them anymore. God stopped him by taking away his hands*." The second doctor had sores growing all over his body, immobilizing him. He also went mad, heard babies screaming and shouting for them to be quiet. Elsa was convinced it was all the children he had killed who came back to haunt him. Their illnesses were God's way of stopping their illegal work.

Andeans place strong value on *ayllu*, (K - family, community), and on complementarity (duality) and reciprocity (see e.g. Bastien 1982, Miles and Leatherman 2003, del Pozo 2005). A common etiology in the Andean medical system is disruption of social relations and obligations, that is creating imbalance between people (del Pozo 2005). One could also get sick by breaching the social contract with God himself. One example was a woman in Toa who had a paralyzed stepson, and according to the community did not look properly after him. She gave birth to a son with *spina bifida*: a spinal disease which may result in reduced functionality and paralysis, amongst other things. Her baby's disease was quickly labeled a divine punishment and a direct consequence of her neglect of her stepson. María, the *auxiliar* at the Monday and Friday clinics, also had experience with God directly influencing her life. She told me that she used to be very unlucky, be in car accidents, get robbed, etc. But after a particularly bad car accident and following hospitalization she had found God. And because she now lived by His rules and prayed every morning and evening she had stayed clear of illness and accidents.

I have chosen to include these examples to show that local health beliefs are complex and often do not conform either to biomedical or pre-Columbian systems of knowledge. The medical pluralism we see in the Andes (Crandon-Malamud 1993, Koss-Chioino, Leatherman et al. 2003) is not a conceptual confusion amongst lay people but something more profound. It is a syncretic pluralism which is encountered even amongst medical specialists. At the book launch of "Sabiduría Ancestral de los Yachaks" (Haas Fettig 2013) the authoring *yachaks* and herbalists all got to conclude the event by providing advice to the audience. They emphasized preserving tradition, taking care of the natural environment (as plants and stones have healing power), the importance of maintaining equilibrium and praying to God. The last *yachak* referenced the 2008 constitution and said there was finally room for the *yachaks'* practice, and he reminded the audience of their power:

> *We can make it rain, by asking it of our heavenly father, of the mother earth and of our ancestors. (…)We are doing it backwards; we turn to the ancestral [medicine] when there is no option. It is better to seek ancestral medicine first, then alternative, and later the occidental [biomedicine]. There are so many unnecessary operations. (…) We don't do a lot of publicity for ourselves but we are powerful and you need to have faith.*

The *yachaks* are the highest Andean specialists, powerful healers who have the combined skills of *fregadores, parteros, curanderos* etc. (del Pozo 2005). A *yachak* has the *curandero's* knowledge of healing with plant remedies, but are also capable of using supernatural remedies and "arrange tables to feed the earth" (Bastien 1982:799) I expected them to have an almost religious faith in the Andean tradition. Rather, they exemplified what the director of the Andean Alternative Hospital (HHACh) had said: "*Andean medicine is knowledge, not religion*". There seem to be no contradiction between the belief in spirits and being a Christian. This syncretism is made possible by pointing to how everything ultimately comes from God. God has the power to bring sickness, and through nature he has provided the cure.

Picture: From the opening ceremony at the book launch of "Sabiduría Ancestral de los Yachaks" (2013)

Cosmology, the sacred landscape

"In the Andean worldview, natural and supernatural features of the suprahuman environment are merged. Features such as mountain peaks, rock outcroppings, streams, and the earth itself, all have personified, spiritual essences" (Larme 1998:1006f). *Apus* are the mountain spirits that protect the Andean *Runas* (Kichwas), on both social and individual levels (Gutman 1998). Mountains are not only mountains, but something divine. In Toa, evangelical Bible studies were held on mountain tops, bearing witness to their continued sacredness, even in the "new" religion. This is a strong proof of the syncretism between Christian and pre-conquest religions that is largely unrecognized by the people themselves. A young woman told me that once she had fallen asleep in a car while her friends were climbing Chimborazo, the mountain that gave name to the province. In her sleep, a white, bearded man had visited her. She was sure it was Chimborazo himself, and due to stories of women who had gotten pregnant by him, she had been worried until her next period came ("*andaba con susto un mes").* The way she personified Chimborazo and her belief in his power to directly influence her, is widespread in the region and corroborated in the book "Sabiduría Ancestral de los Yachaks"

(The yachak's ancestral knowledge) (Haas Fettig 2013) [41]. *Apus* can protect help and heal, and the taller mountains are generally the most powerful ones (Gutman 1998). Places which hold special importance or potency are called *wakas* (Haas Fettig 2013). In the province of Chimborazo there are many of them that are widely recognized such as the dormant volcano Chimborazo and the Lake Colta. The *wakas*, the elements and nature itself are sacred entities that can affect people's health both negatively and positively. The *yachaks* have the capacity to channel nature's powers, and are the only ones who can call on an *apu* (Gutman 1998).

Picture: *Taita* (K- father) Chimborazo, 6268m

Indigenous thought and conceptualization of health and etiology

One of the most central characteristics of indigenous Andean thought is the categorization into dualities. Frequent dualities are high and low, hot and cold, and feminine and masculine (del Pozo 2005). It is very important however to recognize that these dualities are not necessarily the same as similar western oppositions. Everything has hot and cold, feminine and masculine properties. For example the Kichwas distinguish between *kari rumi* (K- male stone) and *warmi rumi* (K- female stone) according to its size, color, texture etc. This is important in healing, as a specific ritual may require e.g. one male and two female stones (see e.g. Haas Fettig 2013). The classification of hot and cold foods has nothing to do with the physical properties of the food. That is, a hot soup can be classified as cold if it contains mainly cold ingredients. Or as Harwood described among Puerto Rican immigrants in the

[41] *Yachak* is Kichwa and is translated to *sabio* in Spanish, or knowledgeable in English.

United States, a cold beer would be classified as "hot" because alcoholic beverages are "hot" (1971 in Helman 2007:55). The classification into hot and cold is important, as excess of one will lead to sickness. This can be internal excess as in having eaten for example too many hot foods, or it can be external excess, getting a fever from being cold or being too long in the sun. Generally people in Toa took great care for naked skin to not be exposed to the sun at any time, as the excess heath would harm them. A balance between the different dualities is important for health. In the Andes to be healthy a person has to be in "a good relation with all the elements in its surroundings, be those natural or human" (del Pozo 2005: 23, my translation). A disturbance in this harmony or an unbalance (*desequilibrio*) can result in sickness (Greenway 1998, Gutman 1998, del Pozo 2005) and healing will therefore involve a restoring of balance. This is not unique to Andean medicine, but is found in many indigenous healing systems such as Canadian Aboriginal, Q'eqchi Maya medicine and even Traditional Chinese Medicine (Waldram 2012:194).

As has been widely reported, Latin Americans tend to classify food and sicknesses into the categories hot and cold (see e.g. Finerman 1989, Graham 2003, Gartin, Brewis et al. 2010, Waldram 2012). Finerman (1989) describes how this is transferred to pharmaceuticals. The classifications of pharmaceuticals depend on what people were treated for. For example, people who have received aspirin for a "hot" disease (fever) classifies the medicine as "cold", while those who have been given it for "cold" ailments (muscle aches) perceive aspirin to be a "hot" remedy (Finerman 1989:169). At the Toan clinics many references were made to the hot and cold classification and probably many more than what I managed to pick up on as they were often very subtle. For example one 12 year old girl came in with a stomach ache, and her mother stated that she drank cold waters. This probably meant that she drank teas made from "cold" herbs as people generally did not drink pure water, and the mother's statement can thus be interpreted as "*we have tried to cure her, but she doesn't get better*". The personnel also used humoral theory in their recommendations at times. For example, María told all the people she vaccinated to wash their arm in cold water to prevent pain and fever.

In the Andes, not only excess heat or cold, or other unbalances can lead to sickness, but spirits, winds and the natural environment may cause harm as will be shown in the next section.

Culture-bound syndromes

The term culture-bound syndrome refers to illnesses which are tied to specific cultures and places. Stress and lower back pain are typical ailments bound to western culture. These are illnesses that are direct results of our lifestyle. They are also connected to our way of thinking about health and sickness. Common symptoms of stress are tiredness, headache, bad temper, weight gain, sleep deprivation and depression. In other cultures it might seem irrational to group these symptoms together, while in our (euro-american) culture we find it natural that people become "stressed" and we can all recognize the symptoms. This is important to keep in mind when reading about syndromes bound to other cultures. Many symptoms will in western thought be unlikely to have the same cause, and often the cause itself seems unlikely, or even fictional. I wish to use this section to present some of the most common culture-bound syndromes in the Andes, because Andean medicine is specialized in responding to those ailments, and understanding the illnesses helps us to understand underlying health conceptualizations.

The culture bound syndromes that are most widely reported from the Andes are *susto* (fright illness) and *mal aire* (evil winds) (see e.g. Crandon 1983, Carey 1993, Crandon-Malamud 1993, McKee 2003, Price 2003)[42]. These are therefore the illnesses I will elaborate on the most, but a wider variety of culture bound syndromes also exist in Latin America, such as *colerín* (anger), *nervos/nervios* (nerves) (e.g. Scheper-Hughes 1992, Larme and Leatherman 2003) and *pena* (sadness) (e.g. Tousignant and Maldonado 1989).

"Susto is recognized in many areas of Latin America, with a multitude of local variations" (Carey 1993:284). It is often referred to as fright illness, and causes can be both natural and supernatural. Frequent causes are sudden loud noises, seeing ghosts or being scared by dogs (ibid). In Toa several people reported that if a wolf saw you before you saw it, your whole body would become paralyzed by fright[43], and you would be unable to scream or move. Culture-bound syndromes in the Andes are not necessarily tied specifically to indigenous culture, as they often are experienced and recognized by mestizos. *Doctora* Andrea once reported that she had been temporarily paralyzed when she encountered a particularly fierce dog. The *auxiliares* were quick to explain that this was a normal reaction when seeing wolves

[42] The authorships Crandon and Crandon-Malamud is the same person, as she has changed her name during her career.
[43] The word for fright is *susto*, it was however unclear if they referred to the specific illness, or just regular fear. Independent of whether or not people thought of this fright as *susto*, I still think it is a useful example.

or half-wolves. "Young children can contract *espanto [susto]* by falling in the street, being threatened by an aggressive dog, or falling out of bed. In vulnerable adults, the illness can come about after a car accident or walk in the forest" (Price 2003:210). Generally, children, women and elderly people are seen as inherently weaker, and more vulnerable to illnesses than others (Larme 1998). Women are especially vulnerable after child birth (ibid).

Susto is dangerous because it can lead to soul-loss, which in some societies are considered lethal and indicated by common symptoms such as:

> "restlessness in sleep, listlessness, loss of appetite, weight loss, disinterest in dress and personal hygiene, loss of energy and strength, depression, introversion, paleness (...) lethargy (...) high fever, diarrhea (...) vomiting, and occasionally leads to paralysis and convulsion" (Crandon 1983:156).

It is widely reported that children are more likely to lose their souls than adults (see e.g: Crandon 1983, Carey 1993, Crandon-Malamud 1993), and that biomedical doctors cannot heal such loss.

Arrieta Chavéz, leader of the Toa parish in 1985 writes in the presentation of a book on traditional medicine from the area that "many of the illnesses in [Toa][44] stem from possession of a malignant being, like the devil (supay) or supernatural forces such as evil winds (huaira) who live in the hills, gorges and certain places known by the people" (1992:4, my translation). *Mal aire* is often "encountered in remote and lonely mountain reaches, ravines, abandoned houses, on empty footpaths (*chaquiñans*), and in the dead of night, in a town's empty streets" (2003:138) Other times witchcraft (*brujería*) might be the cause of the illness. In Toa *mal aire* was seen by some as supernatural while others recognized the illness as stemming from being shocked by a cold wind for example when going outside to urinate in the middle of the night. Twice during my fieldwork I was "diagnosed" with *mal aire*. The second time, it was because of a cold wind in the night followed by dizziness, but the first time my illness was seen as supernatural. I had walked down the steep side of a gorge, where there is barely a *chakiñan* (K= footpath) to follow, to get from my current housing to the primary school. I had promised that I would teach English, and came down to make the arrangements. As the *quebrada* (gorge) was the fastest route it seemed like the natural choice. I also preferred it because there were no houses and therefore no guard dogs threatening to bite me. When I arrived at the

[44] I have substituted the real place name for my pseudonym in the quote to maintain anonymity. The book is also as mentioned removed from the bibliography.

school I was inexplicably tired and could barely sit straight. The teachers, three middle-class, middle-aged mestizos asked me immediately about my route. When they heard the answer they quickly concluded that I was struck by *mal aire*, and told me that I was careless to walk in *lugares botadas* (abandoned, or isolated places). In those places evil winds and energies frequently enters the body of humans. They told me the only way to cure *mal aire* was to be ritually cleansed and I should ask one of my indigenous friends to help me. When I came home I immediately told my friend about my diagnosis, but she just laughed, called it superstition and told me I was probably just tired and needed to rest. I slept until dinner, and felt a lot better.

Evil energies can not only be contracted from winds but can also be transmitted through malignant looks (*mal ojo)*. Babies are especially vulnerable as their energies are *tiernos* (young, pure). An adult who is overcharged with bad energy can transmit this to the baby by looking at it.[45] I was told by a research participant that many *yachaks* avoided shaking hands with other people as a way of protecting themselves against bad energies.

Food

Food is central to health. But the way we talk about food varies according to culture, knowledge base and trends. The media portray countless and contradictory advice and how the public receives it is often linked to popular or cultural ideals. While there seem to be global consensus on food being important for health, there is no consensus about which foods are healthy and why. For example the potato is seen as one of the healthiest things you can eat in the Andes, while many westerners reject it because of its high level of carbohydrates. Potatoes are the main staple in Toa, and people cannot imagine a day without potatoes. Even though, the planning for lunch (the main meal) always started with "*should we make rice or soup?"* it was rare that potatoes were not included in the meal. "*One should eat at least a potato a day to stay healthy, but we exaggerate and often eat ten. A meal without potatoes is like a meal without salt*" I was told.

Often I heard that in the center of Ecuador, especially in Chimborazo people were more inclined towards traditional medicine. "*In every corner they have aloe vera-shakes. The mentality is that the natural is healthier than the occidental."* It struck me that what was

[45] According to the director of HAACh.

meant by traditional medicine was not ritual cleansing, as I imagined, but consumption of natural and traditional food. On the health fair in Toa I was surprised to see that they had also included an "intercultural health" stand with people working for a branch of the Ministry of Public Health (MSP) on intercultural health. I walked over and asked what they were doing, whereby I got the answer "*we promote local foods. We [the indigenous] have adopted a* facilismo[46] *where we eat foods that are processed outside [the communities]. We try to get people to re-value the locally produced foods, such as the quinoa*".

Picture: Man examining the grains at the "intercultural health"-stand

"*Earlier people did not get sick because they ate naturally*" was a frequent statement among young people in Toa. The introduction of foreign and processed food is seen as damaging to the body. But it is a contradictory relationship as many also see this food as a symbol of wealth because it is bought, not produced (Graham 2003). In Toa people used chemical fertilizers and also ate white bread, sodas and cheese doodles, while at the same time pointing to how unhealthy it was. Graham found the same thing in Peruvian Andes, where "[l]ocal foods are considered crucial for health and *misti* [mestizo] food, in spite of its prestige value, can make people sick" (Graham 2003:162). Not only is food tied to health, but traditional medicine is increasingly associated with alimentation. In some aspects, traditional medicine is

[46] Meaning, a tendency to do something simply and without much effort or sacrifice.

reduced to eating naturally, and preventing and curing illness by consuming (or not consuming) certain foods.

Applying Andean healing to sicknesses that are not bound to Andean culture

I got access to two books written about traditional medicine in Chimborazo. The first one was written in 1985[47], and the other, "Sabiduría Ancestral de los Yachaks" was published during my fieldwork. While biomedical professionals wrote the former, the latter is largely written by the *yachaks* themselves. What is interesting to note when comparing these two books, is that while they both describe medicinal plants and how to use them, the book published in 2013 includes a variety of illnesses which are not present in the 1992 book. These newly included illnesses are not bound to indigenous culture, but rather to the urban mestizo, or westernized culture and include infertility, high cholesterol and stress. The *yachaks* have also incorporated "biomedical" diseases such as tuberculosis or anemia. *Susto*, *mal aire*, and *nervios* are still included, but alongside "new" illnesses. This illustrates that traditional knowledge about health is not a static entity, but in continuous development alongside the introduction of new ailments.

That traditional healers have started curing modern diseases also became visible when in November 2013 I visited Omaere Park in Puyo, Amazonia. In this park they grow traditional medicinal plants, and sell natural products based on the knowledge of the indigenous groups Waorani and Shuar. The visit here was the first moment I started thinking about indigenous medicine as becoming increasingly "New Age". Our guide was a north-American hippie-biologist, married to a Shuar woman. His focus when telling us about the uses of various plants was always "Western diseases" such as cancer or infertility. He also made a point out of presenting the ayahuasca vine, a hallucinogenic that has received extensive interest from foreigners. When I asked him about whether indigenous people had always had cures for these new and largely biomedically defined diseases I was told that they had not, but their extensive knowledge of plants and the human body allowed them to discover new cures when

[47] Published in 1992, which as previously mentioned cannot be sited.

needed. In the next section I will look closer into how traditional medicine has changed to fit within urban mestizo society, and in which forms we can find it.

Placing traditional medicine within the health care system

Arthur Kleinman writes that ”health care is described as a *local cultural system composed of three overlapping parts: the popular, professional, and folk sectors*” (Kleinman 1980:50, original emphasis). The popular sphere is the least studied, but most utilized. It is “the lay, non-professional, non-specialist, popular culture arena in which illness is first defined and health care activities initiated” (ibid), and as much as 90% of all sicknesses are handled within this sector. In this thesis I have mainly named this section home-care to emphasize that diagnosis and treatment are being performed at home and in the presence of relatives. The “diagnosis” people give themselves in this sector often defines what kind of treatment they seek out. The professional sector consists of almost exclusively western scientific medicine, although there are cases of professionalized indigenous medicine, mainly in China and India (Kleinman 1980). In Riobamba there is one hospital where indigenous medicine is professionalized. This was briefly mentioned in the previous chapter, and will be elaborated on shortly. Kleinman’s third sphere, the folk sector is specialized, but not professionalized or bureaucratized. In the Andes this sector is dominated by specialists such as *yachaks*, *fregadores* (bone setters[48]) and *parteras* (midwives). The interaction between the three sectors is based mainly on shared patients (Kleinman 1980:59). Kleinman’s division is frequently used within medical anthropology to show how patients flow between the different spheres, and often utilize home care, professional care and folk medicine during the same illness episode. However, it has been argued that these categories have become “less theoretically meaningful and hardly representative for the actual range of medical options available to patients” (Miles 1998:207). For example, according to Kleinman, most traditional healing takes place within the folk sector (1980), but I wish to argue that in Ecuador this way of healing is now spread across all three sectors, complicating the conceptualization of what traditional healing *is*. The medical system often referred to as traditional healing has many

[48] Catherine Oths (2003) writes about the differences between sobadores, fregadores, componedores and hueseros, but for the purpose of this thesis it seems natural to group them together as done with biomedicine, and for the same reason. That is, when contrasting different medical systems, minor variations within one field are of lesser importance. I have therefore chosen the term “bone setters” as a translation although Oths might be in slight disagreement. In the rest of this thesis I will use the term in Spanish.

names. Most frequently in Ecuador people called it *medicina natural*, *medicina/sabiduría ancestral* or *medicina andina*[49]. The term *medicina andina* was often used even if the skills and medicinal plants were acquired in the Amazon. Andean medicine refers to anything from drinking oregano tea when having a stomachache to paying a hospital-employed *yachak* to perform a cleansing ritual. A telling example is trying to position the *partera* (midwife) within one sector. A *partera* could be a particularly skilled woman known to the whole community, she could be hospital employed or she could be a relative with some extra knowledge. Since the terms do not distinguish between the degrees of professionalism, in practice it is extremely difficult to draw any clear lines saying whether or not people trust in and practice traditional medicine. If one uses a broad definition of *medicina andina* everyone, both rural *indigenas* and urban mestizos have knowledge on the field, and frequently utilize it.

Diversifying traditional healing

Although my informants often used the terms *medicina natural*, *medicina/sabiduría ancestral* or *medicina andina* more or less interchangeably when talking about traditional medicine, I think it can be useful to look at how the terms are separated from each other in the literature. This also makes it easier to understand the wide range of forms and uses traditional medicine holds in the Ecuadorian society. In this section I will therefore look at what has been written about Andean medicine, and how this fits with, or has changed into the reality I observed during fieldwork.

Packaged "Natural" Medicine

Commercialized natural medicine was highly visible in Ecuador at the time of my fieldwork. There was a store specializing in natural remedies on almost every block in Riobamba, and every market street had several stands advertising for or selling these products. Some even sold their merchandize on long distance buses. Harvey (2011) has called this "the 'other' public health" as it is somewhat between traditional (Mayan) and biomedical healing, between the local and the global. The marketing in stores and at open air markets in Ecuador was often done by large colorful posters, sometimes accompanied by speeches through megaphones or

[49] Natural medicine, ancestral medicine/knowledge or Andean medicine

loud-speakers. At the Guamote market my friend and I bought pomade which was said to alleviate back pain (made by the same Amazonian worms that were also said to cure pneumonia if ingested) and a natural powder that mixed with water could kill parasites. Both cost about $1. Still, the parasite medication is something everyone in Toa knew how to brew, at least traditionally, but as Miles (1998) note; the form in which it is sold, and especially if the medicine originates in the Amazon, make it seem more potent than what you could make at home.

Picture: Selling natural medicine from the Amazon

Natural medicine refers to anything that is not chemical. But interestingly it is often packed and presented in small white pills, while being described as "completely natural". Perhaps because of this peculiarity Ann Miles calls it "natural" medicine in quotation marks, She also says it is the "most pervasive and obviously commercial alternative medicine in Cuenca, [the third largest city in] Ecuador" (1998:206). She argues that "natural medicine products provide a domain that brings together the usually competing discourses associated with modernity and tradition" (ibid: 207). As van der Geest and Whyte (1989) writes, healing is often objectified through pharmaceuticals and when health clinics lacks medicines people stop showing up. It is this potency and popularity that is played on when "natural" medicines are packaged and sold as pills or in or well-labeled bottles and containers. In contrast to pharmaceuticals, "natural" medicine is generally considered harmless, and patients can freely choose what kind

of product they want. In natural medicine, even vitamins are used and thought of as curative (Miles 1998:215) This is interesting because if the case is that people conceive of vitamins as something they only need when they are ill, or think of them as pills, rather than natural nutrients, it may explain why the doctor in Toa found it easier to give children vitamins than get their parents to produce (or buy) and eat more vegetables. Another reason can, of course, also be a medicalization of larger social problems, such as poverty (see e.g. Scheper-Hughes 1992), an issue that will be further discussed in the following chapter.

Miles writes that although many clients why buy natural medicine in specialized stores had already tried biomedicine, it is important not to view natural medicine as a last resort, or oppositional to biomedicine. Sometimes the choice is made simply because natural remedies are cheaper (Miles 1998). Part of the appeal may also lie in that "[i]n contrast to biomedicine, whose practitioners were reported (…) to be remote and authoritarian, natural medicine stores strive to provide personal and friendly service" (Miles 1998:216), and to allow patients agency in the therapeutic process.

Home care with natural medicine

As in any other society, people will often try to cure themselves at home before seeking out professional help. The Toas had rich knowledge on how to cure minor ailments. In case of a stomach ache or headache people would always brew herbal teas. With fever one could rub an egg on the patient's chest or stomach. Everyone knew that "*limon corta la sangre* (lemon stops the bleeding) and in case of a cut people would sterilize it with lemon, or even mud, and bind it with leaves. I also met an old woman who bound leaves to her head to alleviate a migraine that was so serious that without her head wrap she could not stand straight from pain and dizziness, she said. She had tried chemical medicines, but none had helped her.

Knowledge of plant remedies is first and foremost a female skill, and it is not limited to indigenous women. One of the first things my mestiza host mother in Riobamba showed me was all the medicine plants at her roof top terrace. She showed me one who was *"good for cancer*" and many others that you could use for minor ailments. While I lived with her I got a good impression of her extensive knowledge. Orange juice with brown sugar – *panela* (which she insisted was not sugar at all) and cinnamon was given against a cold, oregano tea for stomach aches, and various teas that where good for stress, headaches, digestion and so on.

Some were seen to have therapeutic effect, while others were preventive. In Toa most women had the same knowledge and also knew how to kill parasites and calm down nerves (*nervios*) or sorrow (*pena*). The difference was that these women did not plant the medicinal plants in ceramic pots on roof tops but grew them (or found) them in their natural surroundings, and when necessary, bought them at markets.

In conversation about plant remedies my host mother frequently stated that "*the indigenous know these things*" or at least that they knew more than her. The younger generation Kichwas often stressed that it was their grandmothers who had extensive knowledge, that the Toas were losing their knowledge. *"It is interesting to walk with the* abuelitas *(grandmothers)*," Jessica told me, "*they always point out plants at the side of the road which are good for this or that.*" Her statement was particularly interesting because I enjoyed walking around with *her* because *she* pointed out all the medicinal plants we passed. Her way of speaking and behaving was also typical. People generally downplayed their own knowledge by pointing to what their grandmothers or the *curanderos* (healers) knew. As I built friendships I gradually learned that people's knowledge of, and faith in what can be labeled "traditional" was far more extensive than they originally let me believe.

Local specialists

According to Ricardo, one of the TAP-students, Toa still had *curanderos* (healers) *parteras* (midwives) *fregadores* and people who performed *cuy*-scans[50] (generally *yachaks*). In the community where I lived there were two *parteras*, but one was too old to work. These where midwives who charged for their services (about 5 dollars). Their role has diminished in recent years as many people migrate and in all the 23 communities of Toa there were less than 15 pregnant women at the time of fieldwork. These women largely sought help from biomedical professionals or relatives. Therefore, specialists with whom one had family ties where the most important practitioners of traditional pre-natal and labor care. A 27 year old neighbor of mine told me that all of her five children had been delivered with the help of her mother in law. She had the skills of a *partera* but only helped her relatives because she was afraid something would go wrong and people could blame her for it. Some women also gave birth

[50] A way of using guinea pigs to diagnose illness by rubbing it over the patient's body, opening it and "reading" the intestines. As my Spanish teacher said: In the U.S. they have Cat-scan, here we have cuy-scan.

without any professional help: *"Why would I pay 5 dollars for a* partera*? It's only birth. I went through all of them [9] alone"* Manuela (54) told me.

One of my neighbors was a *fregadora*, but she never told me about her skill even though she knew I studied such things. I only learned about her skill when her nephew, Francisco, hurt his ankle and was cured by her. That event made me suspect that there were a lot more traditional knowledge and medicine utilized in Toa than people made visible for an anthropology-student. My assumption was supported when in the middle of November I learned that a man I'd had almost daily contact with since my arrival 1st of July, had gone through training with a *yachak* and had sufficient skill to guide ritual baths. He often professed that he would help me in my studies in any way he could, and I was surprised he had not found it fit to tell me sooner. I wondered if people consciously hid this information because of previous bad experiences such as witchcraft accusations and suspicion, or if they simply did not think it relevant to mention. That I more or less stumbled across this information after such a long time in the field also highlighted to the importance of long-lasting fieldworks.

Professionalized specialists

There is a hospital in Riobamba (Hospital Andino Alternativo de Chimborazo)[51] where Andean medicine is professionalized and institutionalized alongside biomedicine and orient-influenced alternative medicine such as magnetism and acupuncture. Here we see a medical pluralism which needs to be understood not as patients navigating various healing systems, but as the utilization of various healing techniques within one system (Stoner 1986). The Andean hospital was created for the indigenous population, and the idea was to put equal importance on the three different practices of medicine and for the patients to be able to choose freely. It was also a way to place an institutional guarantee on ancestral knowledge. This hospital has been unique in not only Ecuador, but also Latin America as a whole, but they are now starting to build similar hospitals at other locations[52]. I went to the hospital to learn more about how traditional medicine is practiced within a modern institution. The *yachak* at the Hospital Andino was unwilling to talk to me. I had expected it, as *yachaks* are

[51] The idea formed in 1996 and construction started in 1998 with the support of a German priest, local religious, governmental and non-governmental organizations (H.A.A.Ch 2014)
[52] Such as in the Imbabura province north in Ecuador. (From interview with the HHACh director)

known to keep their cards close to their chests. This is both a way of securing a competitive position, and a way to avoid accusations of dangerous practices or even witchcraft. Fortunately I got to speak with the *sobadora*; a woman called Tránsito working with illnesses of the bones, from broken legs to arthritis. *Sobadores* are highly respected but in contrast to *yachaks* possess no supernatural power. Oths writes that they encounter "virtually no competition from other healing modalities" (2003:83).

Tránsito had started following an old man when she was nine or ten years. He was a powerful *curador* - healer and she quickly discovered that she had the same talent. Her knowledge was widely reputed and before the Hospital Andino had searched her out she worked from her house where patients came from close and afar, lining up their cars and giving her more than full workdays. Often patients came to her because biomedical doctors had given up on them, or made a mistake. She told me that western-style doctors did not know how to treat broken bones very well. They put the cast on before letting the swelling go away, complicating the healing process and causing the patient unnecessary pain. She did not understand why they did not wait for the swelling to go away, and said that when patients came to her, she took off the cast, put herbs on the broken bone to calm the inflammation and only when the limb was back to normal size she would start the healing. She also said she could cure arthritis which interested me as this was one of the primary complaints[53] of elderly patients visiting the Toa clinics. They normally got sent home with paracetamol for 5 days, and when I asked the doctor she said it was incurable and everyone was bound to have it because of the cold climate and their hard labor. Tránsito however, assured me that she had cured many cases. She told me about one case in particular: an old woman whose severe arthritis had bound her to a wheel chair. She came in the month of august, and for five months she came in for regular treatments. In the beginning she came every second day, then every week, then twice a month, but she kept coming until she was cured and could walk[54]. Healing takes time, Tránsito said, and you need to diagnose well before curing. The diagnose was something she stressed over and over again, saying how some people have soft bones with the capacity to heal quickly while some have got harder ones. She had to know the bones of the patient before knowing how to treat them: *"every patient, every pain is different, to cure well you need to diagnose well."*

[53] According to Seguro Social Campesino's statistics the most common chronic, degenerative ailments where 1) high blood pressure (21 patients), arthritis (11 patients) and coxarthrosis (7 patients).
[54] After eight years she came back with a pain in her knee. She had passed eight entire years with no pain.

The social meaning of illness and healing

In Andean medicine diagnose is integral to the healing, and often include social components. The diagnosis is always individual, and based on the patient's social and personal story. This can be contrasted to biomedicine that focuses on biology and germ theory, and (apart from psychology/psychiatry) completely excludes social factors. Often healers diagnose and treat their patients within a social and communitarian framing. In Andean medicine the patient, and patient's family members, are active participants in the process of setting a diagnosis and performing a cure. Lauris McKee (2003) argues that the curing of *mal aire* functions as an enculturation, where children learn cultural schemas and models. Through their diagnosis and the cure they learn that biological and ritual kin are the only ones that can be fully trusted, that one should not walk in abandon areas, that family should stick together, and they learn about cultural concepts such as weakness and hot and cold.

Setting the diagnosis is a visible action, which often includes breaking an egg, or opening up a guinea pig that has been rubbed over the patient's body. By pointing to physical properties of the egg/guinea pig the healer can make the cause visible, and unquestionable, for the patient. Diagnosis also has a moral element. McKee describes a girl who has gotten sick where after questioning the mother the healer decides that the father who has been out drinking until late have brought *mal aire* to his home, thus making his daughter sick (ibid: 131). The *yachaks* often have important social functions and are seen as leaders and advisors in their communities (del Pozo 2005). Based on my empirical findings, I argue that this is changing. Now their role is fragmented into two poles: on the one hand they are employed at institutions, acquiring another type of medical authority. On the other hand they have been forced to hide their practice and mainly heal relatives and friends. In the communities there is left a vacuum of authority on health, especially on the social aspects of health. One of the changes that may be occurring as a result is that the *auxiliares the enfermería* takes over the *yachaks's* role as health authorities and valued advisors. Further studies are needed to see how the changing role of the *yachaks* influences social life in the communities, and to which degree this is filled by other medical authorities, such as the *auxiliares*.

Christine Greenway writes that "[t]he narratives by healers during healing ceremonies convey Quechua (*runa*) notions of the coexistence of present and past, physical and spiritual, alive and dead, well and sick, *runa* and non*runa*" (2003:93, original emphasis). And that "at times it seems as if families and healers talk about everything *except* the illness, or the specific

complaints, or even the specific patient with whom they are working" (2003:93, original emphasis). This makes sense when we are aware of Andean etiology. Social relations and personal worries also become crucial for the healer to be aware of as in the case where the father's immoral and irresponsible behavior (drunkenness) led to the young girl's sickness. In the introduction I briefly mentioned the woman who became ill because her grandson was born by caesarian section. This emphasizes the importance of a healer to intimately know family relations and social history, pointing back to Tránsito, the *sobadora*'s, statement on how every patient and every illness requires an individual diagnosis. The morality of etiology is further backed up by Greenway when she relates how Quintin, a healer, always guided his clients in future decision making by telling stories that were meant to "admonish, instruct, and remind people of their reciprocal obligations to deities, relatives, and community members" (2003:96). Dramatic and tragic stories were also used to warn people of the "dangers of greed, envy, and selfishness" (ibid). Through Andean healing the patient is thus socialized into cultural values, advised in personal matters, guided through life choices and educated in the potency (both positive and negative) of plants, spirits and *wakas* (sacred places). Andean medicine has clearly held a cultural importance far beyond that of physical healing. It is a holistic system which allows the healer to comment on and evaluate the patients' whole life situation. Biomedicine's failure to assume this role can be the cause of many conflicts between doctors and patients.

Concluding remarks

In this chapter I have presented Andean medicine, and how Andeans conceptualize health and sickness. The Andeans believe local foods, such as potatoes, are vital to health. Mestizo food, although prestigious can be harmful (Graham 2003). Food is so important to health that traditional medicine is sometimes conceptualized solely in terms of consuming natural products.

Andean medicine takes a more holistic approach to healing than biomedicine, addressing not only the whole person, but social relations and external influences from spirits and landscape. Supernatural illnesses are not considered treatable by biomedicine and non-indigenous people (see e.g. Greenway 2003). The Andean belief system has proven to be highly adaptable, mixing a magical landscape with the powers of the Christian God, and transferring the classification of hot and cold onto pharmaceuticals. People are pragmatic in choosing what seems most efficient, affordable or agreeable. There is a preference for accepting vitamins instead of buying expensive fruits, or killing parasites chemically to avoid the bitter taste of plant remedies. Towards the end of the chapter I showed how the causes of illness are perceived to be particular to each case. Each patient needs to be treated based on individual, social and communitarian stories, and in doing so the healer may function as a moral and cultural guide. I argue that biomedicine fails to address the social aspects of illness and disease, making patients feel like the doctor do not care about them. This will be addressed in the two following chapters.

Recently Andean medicine has been revalued, and gain popularity by addressing "western" illnesses, and becoming gradually "westernized" in its form. Paradoxically, the attractiveness of "natural" medicine increases when it is capitalized and marketed in the form of pills or labeled tonic-bottles (Miles 1998). Further, when *yachaks* practice in hospitals their medicine becomes incorporated into a professionalized domain traditionally reserved for biomedicine.

Andean medicine is influenced by biomedicine in the way of addressing illness, while biomedicine is not adapted to Andean illnesses. The power-relation between the two healing modalities is hierarchical with the biomedicine dominating Andean medicine. In the next chapter we will see how the hierarchy is magnified by adding a social dimension. Marginalization of the indigenous population is common in Ecuador, and I will now present how this plays out in health care.

Chapter 4

Social inequalities in health

Introduction

After having presented conceptualizations and practices of both biomedicine and Andean medicine it is now time to turn the focus to the meeting between the two. This will be exemplified mainly through the meeting between the Toa doctor and her patients. In this chapter I want to look at the hierarchies that dominate social life in Ecuador. As in all of Latin America life is in many ways defined by complex hierarchies. These are made on the basis of money, educational level, place of origin and ethnicity. Even though marginalization based on culture, "race"[55] or language is forbidden at a constitutional level, indigenous people are still among the most disadvantaged in Ecuador. The people in Toa are poor indigenous farmers, and consistently placed in the lower part of the social hierarchy. Many of them possessed none of the highly valued qualities such as education, money and fair skin. Physical appearance along with economic status are among the most important markers of social inequality in Latin America, and how this plays out in everyday life will be elaborated on throughout this chapter. I focus on three aspects of Ecuadorian social hierarchies: "Race", profession and poverty, which are specifically important in a health context. I want to show how the people in Toa are structurally placed in a disadvantaged position in relation to the mestizo[56] doctors and how this influences health care. The (perceived) superiority of doctors makes medical consultations uncomfortable for the patients, who often are being judged for their lifestyle and lack of medical knowledge.

[55] As pointed to in the introduction "race" is a contested term, and I choose to write it in quotation marks to indicate that I am aware of the debate around it.

[56] Mestizo means mixed, a term originally used for children of Spanish fathers and Indian mothers. In modern Ecuador almost everyone recognize a mixed heritage, and the term "mestizo" generally refers to anyone who does not identify as indigenous or have obvious indigenous traits.

Social hierarchies

In Ecuador social hierarchies are institutionalized, even at a linguistic level. For example you use the informal *tú* with your social equals, while everyone of a higher status or rank than you, such as a teacher, a police officer, a doctor or your boss, as well as every person who is at least ten years older than you, needs without exception to be addressed with the formal *usted*. In the indigenous countryside, probably because of the influence from Kichwa, this also extends to everyone outside your immediate family. It is also customary to address all (older) men with the polite title *don* in front of their name[57]. Further, anyone with a bachelor degree should be addressed with the title *licenciado/a*[58], a person holding a master's degree is an *ingeniero/a*, and a person with a doctorate (or a medical professional) is *doctor(a)*. Addressing people with educational titles seems to be more frequent in rural than urban areas probably due to a higher percentage of the urban population actually holding such degrees. These linguistic traits point to important characteristics of the social hierarchies in Ecuador. The above mentioned markers are just a few in a line of dichotomies (young – old, female – male, uneducated – educated, poor – rich, rural – urban, Kichwa – Spanish, indigenous – white) that functions more like a continuum where moving from the former to the latter is seen as improving yourself. It is obvious from this that indigenous peasants, holding none of the valued attributes, are placed low at the social ladder.

"Racial" hierarchies

For 500 years social hierarchies have followed "race lines" as was discussed in the introduction. Now this is beginning to change, with indigenous people getting educated and acquiring well paid, urban jobs, while many mestizos live in poverty. People therefore have to rethink their own position in relation to others, and struggle to define their own self and identity in an advantageous way related to "the other". In this section I want to look at how people talk and conceive of "race" in Ecuador today. Most important are the tensions between the mestizo and the indigenous population, but also within these groups. As we saw in the introduction, "race", "culture" and "ethnicity" are not easily definable concepts. They build on long political and theoretical histories, and may connote different things in different

[57] The use of *dona* for females is less frequent.
[58] The ending "o"/"a" marks male and female in Spanish.

setting. As mentioned, I have chosen to use the word "race" because it is what my research participants themselves do.

Racism and racial ambivalence

Skin color is an important marker of beauty and status, and many women apply facial creams that promise to make the skin whiter. It surprised me how much of a consensus it was on the preference of the white, tall, blond and blue eyed. *Doctor* Andrés in the Toa *Seguro*[59] clinic told me that indigenous men got infected with sexually transmittable diseases (STDs) because *"when they go into the cities and see beautiful, white blonde women – like you, they know they can never have them so they go and buy them, not knowing that the blonde prostitute will be the most used and therefore most likely to be infected".* In this simple phrase we can see a brief outline of the whole social hierarchy. *Doctor* Andrés showed how white blond women were the ideal, also for him, while he set himself as a mestizo above the indigenous people, whom he largely viewed as ignorant and unlikely to attract the women considered most beautiful. Being a blond and tall woman living in an indigenous community I was faced daily with envy of my own whiteness, and peoples' lacking appreciation of their own appearance. It was truly unsettling for me to come to terms with how people, both mestizos and indigenous, saw me as social mobility and beauty ideals embodied.

While I lived in Riobamba I asked my host mother several times about the existence of discrimination against indigenous people, and was consistently told that it no longer existed, as all Ecuadorians had equal rights. That did not mean that there was no racism. After I moved to Toa it became clear that while there was no official marginalization, social discrimination was frequent, although at times very subtle. It was those small hints like the way people laughed at me when they noticed the change in my accent after I had moved to Toa, I sounded like an *indígena*, they said. Or when an *indígena* dancer on TV was referred to as beautiful, adding that "they used to be so dirty". But sometimes the racism was very explicit; once I was told that I behaved "Indian" – pointing to my long stay in Toa, when what they really meant was that I was rude.

[59] Seguro Social Campesino – peasants' social insurance, a branch of IESS, and the only alternative to the state clinics.

In Toa I got especially close to one family, where the son Ramiro was 27 and still unmarried. This was highly unusual as it is most common to marry while in high school, or right after. The whole community made endless half serious jokes about my relationship to Ramiro. After a couple of weeks I was commonly known as Ramiro's fiancé, and a few weeks later, as we got to know each other it became a joke amongst ourselves. When I visited my host family in Riobamba it felt natural to tell them that the Toas were "marrying me off". I was proud of it, because it made me feel accepted into the community. My host mother asked to see a picture, and responded that he was "*so ugly, too Indian*" and that I "*should never marry someone like him*." I was offended on his part, at the same time as I tried to explain that we were not actually going to marry. The new student who lived there, a 17 year old boy from Estonia, broke in and told me in English that they also deemed his Ecuadorian girlfriend to be ugly because of her black curls, and could not believe he chose her over his blond ex in Estonia. In my view, they were different but equally pretty. Our love interest, although imaginary on my part, started off a discussion about marriages across race and socioeconomic status. My host uncle voiced that black soccer players could only get white women to marry them because of their money, followed by the question if I would have considered marrying a black man. My Ecuadorian conversation partners did not believe me when I said that skin color would never be a defining factor for me, and not something I saw as characterizing a person. When my host mother thought she finally understood she explained to her brother that "*the* gringos[60] *are not racist like us*". Neither of us were unable to hide our surprise: he, because it was unconceivable that anyone, let alone a girl with all their valued physical attributes, could not be racist, and I, because it shocked me how little effort was made to hide their racism.

I have come to believe, that racism is so naturalized that people do not see a contradiction between claiming there is no discrimination (referring to equal rights) and preferring a social segregation. But the Ecuadorian racism is not as simple as "white is good, dark is bad". It is also a question of lineage. My host mother (56 and unmarried) continued by claiming that she herself would never have married a black or indigenous man. It was not just the skin color, but how heritage is conceptualized (Ystanes 2011). She exemplified by pointing to the fact that her brother in law had very dark skin. This was not seen as important because he did not have "African blood", that is he did not come from Esmeraldas (the region with largest percentage of African-Ecuadorians). My host mother thus placed herself within a colonial tradition where a focus on lineage created a situation were legal color and actual skin color

[60] Foreigners, mainly North Americans and Europeans.

did not necessarily correspond (Martinez-Alier 1989, Ystanes 2011)[61]. This man, though, with his "acceptable darkness" had light enough skin for me to never have noticed that he was darker than the others, pointing to how sensitive Ecuadorians are to nuances in skin color. What sat him apart in my eyes was his height, almost 190cm, a giant by local standards. And since being short is associated with the indigenous population maybe it was precisely his height that "redeemed" his darkness?

Charles R. Hale writes that "Indians can 'improve themselves' but their success is measured largely in the extent to which they manage to distance themselves from indigenous culture and, ultimately, indigenous identity" (2006:115). "Race" is flexible and often a matter of appearance rather than heritage. In Brazil, people with *some* African ancestry may be described with a wide range of terms including *white* (Edmonds 2010:126, original emphasis). My host mother's views exemplify how much ambivalence and flexibility the concept of "race" holds in Ecuador. Ramiro, was too Indian for me, her brother-in-law was dark-skinned, but not stigmatized because of it. My mestiza host mother in Riobamba frequently made an example of Dr. D when talking about how some indigenous people had managed to improve themselves, or get ahead. He had moved to the United States at the age of seven, become a medical doctor and started the NGO I worked with. Dr. D would always be "Indian", in my host mother's view, but he had done well "in spite of it". What my host mother's views open up for is social mobility, and flexibility of "racial" categories. Being a "good Indian" or *"indio permitido"* to use Hale's term means different things for different people, which is partly why Latin American societies today experience what he coins "racial ambivalence" (Hale 2006). This ambivalence also stems from an uneasy acceptance and problematic definition of what it means to be "mestizo". One is always in danger of becoming "too Indian".

[61] Martinez-Atelier is the same author as the previously sited Stolcke.

"Racial" tensions

In Ecuador I saw several distinct ways of being and talking about indigenous people. Central to all definitions was marginalization and the classification as "the other". What differed was whether poverty, "dirtiness" and "backwardness" was seen as intrinsically "Indian" or not. With this I mean that many people increasingly saw indigenous identity as something positive, which I will come back to shortly. Also, views differed as to whether "improving oneself" was thought of as moving away from all things indigenous or to find room for a cultural identity in a mixed, modern society. As mentioned in the introduction, in Ecuador ethnicity is an identity open to navigation and change. In fact, ethnic or "racial" identities are so contested that before the 2010 census there were large campaigns to "*autoidentificarse*" (self-identify) as indigenous[62]. This was seen as necessary because it was discovered that official numbers counting the indigenous population was far too low.[63](Chisaguano 2006) Defining oneself as indigenous has been to accept a marginalized identity, and may be why many reject such an identity, much like how people may reject being labeled "poor" (Broch-Due 1999). Because of social stigma and the multitude of indigenous Ecuadorian identities, most indigenous people today identify with place of origin. They rarely put all Kichwa-speakers, and never all indigenous people under the same label (Sánchez-Parga 2013).

The Toas explained that their people had been subject to a lot of discrimination, but with the new president[64] they could study and work like everyone else. They used to be seen as animals, as beasts of burden, and even their language used to be shunned. With the new government this was finally changing. Though new laws forbid discrimination and secure equal rights to work and education the social stigma is hard to get rid of. Most *mestizos* certainly have an us-them attitude towards the indigenous population. They are often spoken of as "them", "they", " the indigenous", "*la gente del campo*" or even "*esa gente*" – those people. The Spanish word *gente* means *people* but contrasted to *pueblo* (literally town, but also people) or *persona* (person), both of which indicate in-group sympathy, *gente* may imply apathy and disagreement; in other words defining *la gente* as the out-group – *the other*[65]. People do not consistently and consciously use them as such, but we see tendencies in word

[62] Observed during my 6 months stay in Quito, fall 2010.
[63] According to the 2010 census 7% (6,8 in 2001) self-identify as indigenous (INEC 2014) while the indigenous rights organizations operate with numbers from 30% to 70% of the national population (Chisaguano 2006)
[64] Rafael Correa has been president since 2007 (PDBA 2014). He is the first Ecuadorian president to be reelected twice (2009 and 2013). Correa has profiled himself as a friend of the poor, the indigenous and the environment.
[65] My Spanish teacher who first pointed these nuances out to me also argued that one of Ecuador's ex-presidents Abdalá Bucarám (" El Loco", aug. 1996- feb.1997) lost the presidency partly because he referred to the voters as *"gente".*

choices such as "*un pueblo unido*" (a united people) and "*esa gente*" (those people) were the former is clearly more positively charged than the latter. The doctors in Toa and other visiting health professionals frequently mentioned how difficult it was to "*educar a la gente*" (educate the people), and when I asked what the greatest challenge to health care in Toa was I was given answers such as "*their culture*" or "*that people don't understand*".

Urban mestizos, like the indigenous, told me marginalization no longer existed. It was now entirely possible to have indigenous people in the government, and even as president. But not everyone favored this development. Susana, a relatively well-off mestiza, explained how we could now see a reverse marginalization; what Hale (2006) refers to as "the discourse of reverse racism". This discourse points to how indigenous liberation has gone too far, and if not stopped or controlled, the mestizos will soon find themselves marginalized (ibid). Having no common origin, ancestral land-rights or an "endangered" culture in need of preservation, mestizos fear becoming forgotten. Susana was from Licto, 18km south of Riobamba, where a man from "*el campo*" (the [indigenous] countryside) was elected town president. Horrified about how he only prioritized the rural areas, leaving the town center to decay, she exlaimed: "*It is impossible for us to* seguir adelante *(get ahead*[66]*) when all the money disappears to the communities. He should prioritize the center; after all it is* there *that he is elected!*" I carefully asked if not the surrounding communities belong to the town where he was elected, thus putting them under his governance as well, but Susana didn't want to hear it: "*yes, but it has never been like that. It should not be the priority. I have friends who still live in Licto and they tell me the* indígenas *are telling them to wait. That it is their turn now.* Son rebeldes ellos *(they are rebels)*". Her husband joined the conversation commenting on how even the president of the republic is only prioritizing the countryside and the indigenous these days. Susana's response deserves to be quoted at full length:

> *Yes, we in the middle-class are completely forgotten, as if we do not matter. There are now indigenous people in the government and they only care about their own, even if many of them have a lot more than we do. It is impossible. In Licto all the mestizos migrate to Riobamba or Quito. The town is filled up with* gente del campo *(rural [indigenous] people), and they do not change their way of living when they come into town!*

[66] The ideas of "getting ahead" or "improving oneself" (*superarse*) are common among poor latin americans, and often involve rural to urban migration only to result in disappointment and abusive working conditions as described by e.g. Miles (2000) and Leinaweaver (2008).

Susana's view expresses a disdain for the *campo* or indigenous country-side way of living. They are not "*indios permitidos*" - good or allowed Indians. At the same time those who manage to move into the urban political sphere traditionally dominated by the mestizos are feared for their power to become the discriminators in their struggle for justice. The discourse of reverse racism can be used to deny them such power (Hale 2006). The only "Indian" there seem to be room for is the one that dances in colorful outfits at cultural events and TV. This also point back to the concept of beauty. While there is a large consensus all over Latin America on classical "European" or "northern" appearances being the most beautiful, there has emerged local beauty contest for various indigenous groups. Interestingly the focus here is often not on beauty as such, but on who best represent "authentic ethnicity" (Borland 1996, McAllister 1996, Schackt 2005). Keesing has suggested that as part of the nation building process in ethnically heterogeneous countries, a suppression of indigenous ways of living and thinking happens simultaneously as a fossilized or fetishized image of dress, music and dance is celebrated (Keesing 1989:31).

In addition to some educated indigenous people there is a portion of the Ecuadorian mestizo society, urban and educated who find new value in indigenous heritage. They talk about a common history with Andean culture-bound-syndromes, healing techniques and knowledge not as something belonging particularly to "the indigenous", but rather, a part of "national culture". There is also a constitutional focus on the country being multinational, with every nation[67] of equal worth. Unfortunately images that are supposed to represent a locality or ethnicity often use a standardized picture of "the indigenous" thus offending all who do not feel represented. Indigenous groups are often very conscious of local history and identity, and unlikely to accept a generic definition as "indigenous" (Sánchez-Parga 2013). Many may take offence if they are confused with neighboring communities (Crain 1990). For example, a mestizo friend of mine who worked with a food distribution program for the United Nation explained how people complained about not being represented even though they had a white person, a mestizo, a Kichwa and a black Ecuadorian. In Toa, I several times I heard people complain about Otavaleños[68] always being used to portray all highland Kichwas, and the fact that *their* dialect was used in the standardization of the Kichwa language. Local history and identity has for many become a source of pride. Many Toas chose to work in the fields with

[67] "Nation" in this context means "people" or "culture", such as Shuar, Ashuar, Puruwa-Kichwa etc.
[68] An Otavaleño is a person from the northern town Otavalo, in Imbabura province. The Otavaleños has managed to prosper because of a large market selling locally produced handicrafts, such as ponchos and jewelry. Their success is renowned nationally and internationally. For further information on the Otavalo Market and the role of the Otaveleños in Ecuadorian society see e.g. Salomon (1981), Korovkin (2001) and Colloredo-Mansfeld (2002)

western style clothes[69] but to wear traditional clothing in town. This is a good example of indigenous, and local pride, as style of dress is localized. Leaving indigenous clothing behind has been seen as part of improving yourself, what many anthropologists have referred to as whitening or *blanqueamiento* (see e.g. Price 2003, Leinaweaver 2008).

The way everyone assumed me to be collecting information about medicinal plants can be understood as part of an increased sense of local and cultural pride. Many have seen how ancestral medicine attract (New Age) tourists to the country and embrace the recognition. Several communities in Toa worked towards the purpose of attracting more tourists, both nationals and internationals, by building museums, over-night lodges, statues of local heroes and making parks with local plants. They were striving to "get ahead" on their own terms, profiting on the marketing of their own culture. One of the strangest forms the indigenous awareness or pride took was a lecture series for girls who got scholarships from the NGO I was affiliated with. They hired a mestizo woman to tell indigenous children about their cultural heritage, and the importance of being proud of their identity. She stressed how leaving their clothing or language behind was rejecting, or losing, their whole culture. I wondered if not denying change in such a way was discriminating in itself. Appadurai writes that often people are classified into either the category of cultural actor, that is a person of the past, or as an economic actor (2004:60). Following this line of thought, defining indigenous people as "bearers of culture" exclude them from progress and modernity. This point of view is backed up by Keesing who writes that the "symbolic material of cultures (…) serves ideological ends, reinforcing the power of some, the subordination of others" (1989:36). What Keesing refers to is a Pacific tradition of reinventing and bending cultural rules to serve the purpose of new political leaders. This can be transferred to how dominant social groups in Ecuador influences the way indigenous people are able to play out their ethnic identity, note the discussion on "reversed racism". It also points to the argument that if indigenous groups focus on reverence for the part of local culture that has survived colonization, that will counteract the "deep anger over the generations of destruction" (Keesing 1989:36).

[69] In Toa women always wore *anacu* (indigenous skirts) and mostly *balleta* (traditional scarf). The distinction I mention here is more about wearing the white embroided blouse (that old people always wear and children never wear). When I say western clothes I thus mean sweaters, although on two occasions I saw women working their fields in pants.

Professional hierarchies

As we have seen, being indigenous is still largely a stigmatized identity, but in Ecuador the social distinctions are much more encompassing. For the purpose of this thesis it is important to also look at the power relations between professionals and lay people, or more specifically doctors and their patients. The following example shows how mestiza patients bend to the doctor's superior status, and suffers through hours of waiting, because it is just the way of things. The women I describe are my 56 year old host mother, Elsa, and her 83 year old mother. They are lower middle-class urban mestizas, showing that patients being poorly treated by doctors and the health care system in general do not only occur in rural settings, or with indigenous patients.

One morning I went to the IESS[70] hospital in Riobamba with Elsa and her mother. We came an hour early in case of cancellations, but the computer system was down and we had to wait over three hours. When finally the system came back and we got to see the doctor neither Elsa nor her mother was complaining, "*Oh no trouble at all waiting*, doctorita, *these things happen*." Of the 45 minutes we spent in the room with the doctor she spent probably 40 on the phone. While on the phone she was writing prescriptions, asking a few questions and even sent Elsa with some papers to another doctor across the hall. The patient and especially her daughter kept smiling politely throughout the consultation while I sat quietly and fascinated in a corner. When we left, Elsa started complaining. I was sort of relieved that it was not only me who was shocked by the doctor's behavior (especially since the phone call included her defending herself against having neglected a patient who died of swine flu). Elsa told me that even though she was annoyed she could never show it. The doctors were used to being treated with a lot of respect, never being contradicted and always being called "*doctorita,*" "-ita" in this case being a suffix that marks respect, not the fond "little" that often is used in Spanish.

In Toa this high respect bordered on fear of the doctors. One day we were at the clinic in one of the lower and extremely poor communities in Toa. A woman of about 35 years came in with a toothache. She lay down on the examination table and the dentist brought in a bucket and a few instruments. All of a sudden when I thought she was done the patient must have whispered something inaudible because the dentist exclaimed "*What? It was the wrong molar? But I tapped my mirror against it and you said it was the right one! Oh, this hurts my heart; I don't like pulling molars in the first place*." She was placing the blame on the patient

[70] *Instituto Ecuatoriano de Seguro Social* (Ecuadorian Institute of Social Insurance)

and at no point was there an apology. The patient never said anything either, just covered her face with her hands, and accepted that the dentist pull the other tooth as well.

To the dentist's defense many people in Toa visit the dentist so rarely that it is not uncommon that two or three teeth need to be pulled when they do go. In addition, the clinics lack equipment to properly treat bad teeth[71]. When the patient has several bad teeth the dentist in Toa usually pulls the one that hurts the most, recommends them to come back the next week to pull the second one, and so on. If this was the case with this particular patient I am unsure of, as I was not present at the initial examination,[72] but from the dentists exclamation it seems unlikely. In any case, what is important to draw from this case is the lack of response from the patient. I would have expected her to yell at the dentist or at least have some strong reaction, but she stayed calm. I wonder if an urban mestizo patient would stay as calm, and told my host family in Riobamba about the case to see how they responded. They were all horrified, exclaiming that the dentist should be jailed. Elsa pointed to the "racial" aspect of the matter by saying "*como son indiecitas no importan para la doctora"* (as they are Indians, they don't matter to the doctor). I hoped it was not true, but knowing the history of how rural, indigenous areas have been consistently under-prioritized and used as training ground for newly educated through the *rurales*-system[73], Elsa's opinion was not particularly unreasonable.

While there definitely were some conflicts between the patients and their dentists, there were more with the doctor. The first time I met *doctora* Andrea we were at the second most remote clinic, serving one of the largest communities in Toa. It was cold, and there were no patients so the doctor and dentist decided to make coffee and breakfast. After a couple of hours the doctor decided we should go and do home visits. We were about to leave when an old barefoot woman showed up. The doctor rejected her saying: "*you need to come earlier, at 8*". She did not speak Spanish very well but managed to say she had come as soon as she woke up. The doctor did not accept the excuse, and was inpatient to leave while the woman kept speaking to one of the TAP-girls[74]. I tried suggesting that we could go to the patient's house,

[71] Cf. Scheper-Huges' description of Dr. "Tiradentes", the dentist who because of lacking equipment had little choice but to pull teeth when patients were in pain (1992:204f)

[72] I was in the doctor´s office. The dentist did not have enough light in her own office and brought the patient in to the other office. Only the "Tuesday" clinic had a dentist's chair, so changing office also meant moving from a normal chair to a doctor's examination table.

[73] As mentioned newly educated doctors and nurses are sent to the country-side where they are obliged to work a full year, largely without supervision, before they can apply for steady (city) jobs. This can be paralleled to the high numbers of plastic surgeries performed by residents in Brazil. Poor patients get free cosmetic surgeries and the residents get the experience they need in order to gain private employment in the future (Edmonds 2010).

[74] Technicians in primary health care. Their role is outlined in chapter 2, and will be further discussed in chapter 5.

that way we could get the statistics of having done home visits and the patient would be treated. The doctor laughed: "*no, it is* way *too far to her house. I'm sorry but I have to teach them to come earlier*." After being pressured from those who spoke Kichwa and me, and after having spent ten minutes discussing the matter she finally asked the patient what was wrong. Her whole body, *los huesos* (the bones) were hurting. She got paracetamol for 4 days.

Another case which particularly caught my attention was when a teenage girl and her mother came into the Monday clinic early in October. The girl had a pain in her heart and wanted an x-ray. Rather than addressing the pain, the doctor kept tidying her desk while asking why they wanted an x-ray in particular. Only after they had repeated that the girl had a pain in her heart several times, did the doctor tell them that an x-ray can only see the bone structure and not muscles, like the heart. The patient's mother mumbled something about the pain, not the x-ray being her primary concern while the doctor, now visibly angry and impatient, continued scolding them: "*You cannot come in here and just ask for an x-ray without knowing what it is. You need to know what you ask for!*" The patients, who came in asking for help, ended up being reprimanded for their lack of knowledge. It was clear that the doctor did not like that they came in with an already formed opinion about their diagnosis and a specific wish for their treatment. After an examination of the patient *doctora* Andrea concluded that it was a vitamin B deficiency which caused the nerves in her chest area to be hypersensitive. She prescribed five injections of vitamin B to be administered every other day for ten days. Since the doctor was only at the clinic on Mondays, they had to count on María, the *auxiliar*'s willingness to set the injections even when it was really her vacation.

There are several things that are important to highlight her. Firstly, it is obvious that the patient and her mother tries and fails in their attempt to please the doctor. The Toas frequently stated that being able to see the inside of the body, and using technology to cure diseases that traditional medicine could not treat were the most positive aspect of biomedicine. When they specifically ask for an x-ray they try to present themselves as actively choosing biomedicine and thus avoid being scolded for trusting traditional healers and quacks. The doctor did not realize this, and got irritated because the patients did not know what they are asking for. Another important aspect is the fact that the doctor gave the patient a diagnosis which was radically different from the one she had given herself. As we saw in the previous chapter this is strange compared to Andean medicine where healer, patient and the patient's family members often set the diagnosis together. The suspected diagnosis is verified by examining e.g. an egg, or a guinea pig's intestines. That way the diagnosis becomes visible. For the girl,

Anita, and her mother vitamin B deficiency was a very foreign and therefore unlikely diagnosis. Not just because it did not correspond to the etiology that had decided on, but because inadequate schooling makes most Toas unaware of what vitamins are, and what they do for our bodies. The doctor made no attempts to explain this, but gave them a quick fix in form of injections. The girl seemed skeptical to needles, and I tried to ask the doctor about giving her dietary advice. *Doctora* Andrea explained to me that because of poverty, they would never be able to eat enough meat anyway. If she was unaware of, or simply unwilling to explain about, other sources of vitamin B, was unclear.

One could argue that the doctors' personality is the reason for the poor treatment the patients received. Addressing this potential flaw in my argument and for the overall purpose of this thesis there are two things that are particularly important to remember: The first one is, pointing back to chapter 2, that Ecuadorian rural health care is inadequate for patients and employees alike. Having consistently been under-prioritized patients are highly negative to biomedical health care. For the doctor, the difficulties of facing negative, distrusting patients on an everyday basis are added on top of having to work in cold, remote areas, frequently without access to food or transportation. Staying motivated and in a good mood would be difficult for anyone. Also, only having access to one doctor, that doctor's personality *is* important for health care and for patients' lived experience of biomedicine. The second aspect we must keep in mind is that the social hierarchies - so naturalized in the Ecuadorian society - allow doctors to play out a difficult personality without consequence. I never observed a patient asking a doctor to hurry up, and it would be highly unexpected for an uneducated indigenous patient to denounce her doctor's mistake. Further, empirical data suggests that a doctor do not need to accept that the patients oppose her, but can freely ignore them or verbally abuse them until her saying is accepted as truth. There is both a structural and social discrimination of rural patients, and their condition is worsened by their poverty.

Poverty and health

> "*Many foreigners are surprised that we are not poor the way they are in Africa. Here,* gracias a Dios *(thank God) we always have something to eat; even if it's only* máchica *(barley flour).*" – Ángel (52)

The Toas defined themselves as poor, but took pride in being able to cope with that poverty; providing food for their families under difficult living conditions. During my fieldwork it was the season of potato harvest and the market value of *quintales* (potato sacks of a 100lb, or 46kg) dropped to as little as 5 dollars. Selling potatoes was not very profitable this year, but the work was as hard as ever. The hardship of poverty has a direct consequence for people's health and well-being: My neighbor, Manuela had a constant back ache as so many of the women of her age group. Although she looked like an old woman she was only 54; 9 child births and a life time of hard labor had taken its toll. Her children were preoccupied because she had high blood pressure and always worried too much. They frequently kept secrets from her to avoid upsetting her, as they believed emotional turmoil would make her sick. She often complained of back pain, had frequent headaches and her bones hurt. Around Christmas 2012 she had been hospitalized for several weeks because of pain in her bones, and her family members agreed it was because she used to peel garlics in cold water for a living. Manuela was not healthy, but although complaining, she kept carrying heavy loads on her back and was doing hard work every day. She would never let me carry anything for her because, ironically, she was afraid that I would hurt my back. She did let her daughters help, as their bodies were "used to it". Manuela mentioned a few times that she might go see the doctor at the *Seguro* clinic but never went. Her daughters worried and tried their best to help her. One bought pomade made from Amazonian worms at a market and when she had time she rubbed it into her mother's back before they went to bed. Another bought an electric massager. Manuela was grateful, but she said it was also difficult as she could not apply either without the help of her daughters.

Although in poor health, Manuela could not afford to be sick. When you live in poverty being sick is a luxury, and defined by not being able to work. A person is sick when they stay in bed, have to see a doctor, or have to go to the hospital, and since it is a luxury they cannot afford - they endure. It seems to me that the gray zone between being healthy and being sick is larger in Toa than in western societies. Kathryn S. Oths writes that as a direct consequence of highlanders hard work they will "bear a tremendous amount of musculoskeletal pain and

illness" (Oths 2003:67). She points to the very real possibility of dying of hunger rather than pain if they stop working, and that this has led to a particular form of stoicism she calls *aguantismo*[75]. The pain has become naturalized to such a degree that medical help is sought only when people are incapable of working (ibid). Manuela and her son (27) were the only ones in the family who did not have at least part time employment outside the agricultural sector. It thus fell on them to feed the animals, sow and harvest. Neither could be sick as that would double the work load of the other, and they already worked the 12 hours of daylight. The son fed the cows in a fever because someone had to do it. Not until his stomach ache had kept him from sleeping three days in a row and became unbearable did he wake his family who brought him for emergency care at a private clinic in the city. It turned out he had a beginning stomach ulcer and after a short treatment, he was sent home but had to follow strict dietary rules. He was lucky to be able to seek private care. Had his brother not had a car, or had he not had 20 dollars to pay the doctor this would not have been an option. It adds to the story that he had been diagnosed with stomach ulcers several times, and still when he went to the *Seguro* clinic in Toa complaining about stomach ache, they gave him medicines to kill parasites, and told him to come back if he did not feel better.

The "culture of poverty" and poverty related stigmatization

> "Poverty is many things, all of them bad. It is material deprivation and desperation. It is lack of security and dignity. It is exposure to risk and high costs for thin comforts. It is inequality materialized" (Appadurai 2004:64).

Living in poverty poses a risk to human health, not just physically in terms of poor sanitation and unsafe living and working conditions, but also psychologically as economic insecurity increases the risk of anxiety and depression (Martin 2010, Han 2012). At the same time being healthy is, in many societies, increasingly seen as a personal responsibility (Dumit 2012), and thus being sick becomes a failure to "improve oneself" so to speak, and grounds for social stigmatization. Katz writes that "[t]he undeserving poor, the culture of poverty, and the underclass are moral statuses identified by source of dependence, the behavior with which it is associated, its transmission to children, and its crystallization into cultural patterns" (Katz 1989:10). This very much exemplifies the way poor, indigenous *campesinos* (peasants) are

[75] From the Spanish verb "aguantar" = to endure.

seen by the Toa doctor and other Ecuadorian mestizos. Instead of seeing a structural injustice leading to their poverty and poor health, the Toas are seen as having something in their culture that stops them from "understanding" or "wanting to improve" their health and living conditions. Pointing to a culture of poverty provides an explanation for why some people do not succeed in a modernizing market-oriented society (O'Connor 2001). Several people I met working in one way or another with health related issues in Toa and other rural areas[76] stated that their culture was the biggest problem. They did not *want* to understand that they needed to wash their water tanks and they did not want to produce vegetables for family consumption as there was no economic profit in it. Several times I heard people tell the Toas that "poverty is not an excuse to be dirty, or have a dirty home", which is more an insult than a recommendation. Agricultural work necessarily involves getting your hands dirty in the literal sense. Further, the fact that rural areas have never been a political priority has created a situation where the peasants themselves had to build water tanks, and tubes. They have created a system where one main water tube leads down to a cluster of houses, and each house connects a private, smaller tube when they need water. The tubes that are not in use are left lying untapped, dirt enters, and the water arrives unsafe to the households. It is almost impossible to keep the tanks clean.

I argue that for the doctors it was easier to pinpoint the problems they saw as easily fixable by individuals, rather than the fact that this was a people forgotten by the government who had to provide and purify their own water. It would also not have been realistic for the health team to try and address these larger issues. They did, however, have one campaign revolving waste disposal[77]. The Toas' poverty and physical and social distance from the political centers were the real problems. João Biehl argues that public health has moved away from prevention towards more technical solutions such as providing medicines (2007, in Marsland and Prince 2012:457). This describes what is happening in Toa where the doctor aims to give people medicine to kill parasites every six months while no one seems to care about safe water

[76] One man who came to examine the water supply, two women working with the Ministry of Public Health, visiting all rural schools in a health bus, checking up on the children, and giving them and their parents (mostly mothers) education in nutrition and hygiene, one *rural* who rotated different clinics in Chimborazo, the coordinator of the NGO I worked with, a psychologist working with the same NGO, a man working with a UN nutrition program, in addition to the people with steady jobs at the clinics.

[77] The health team tried to get people to not burn, bury, or throw waste at the side of the roads. Collecting and selling recyclables was one option but extremely unprofitable. The other option was bringing waste to Riobamba and dispose of it in appropriate containers.

supply[78]. When no one treats the root of the problems it fell to the doctor to treat the symptoms.

During my interview with Dr. Andrés at the *Seguro* clinic I asked him what he saw as the biggest health related challenge in Toa, and he gave me the stereotypical answer: Their culture.

Me: *What does that mean?*

Andrés: *It means that it is difficult that the people* (la gente) *understands what we want to give them. They don't understand, or don't want to understand, what prevention and promotion is. They only want, or only accept medication. Because of their culture, they almost don't understand well* (por su cultura casi no entienden bien).

It is not difficult to understand that this perception complicates the relationship between doctors and their patients. When seeking help, people do not like to be blamed for causing their own problems. Having health care personnel that do not understand their patients' daily struggles and who blames their culture for their sickness is problematic in many ways: It can lead to professionals overlooking serious diseases as they expect every stomach ache to be a parasite infection, like it happened with Manuela's son. It can reduce patients desire to seek out help when ill, and it makes the meeting with the health care personnel uncomfortable for the patients.

Doctors are socially perceived as the superiors of their patients which gives them room to play out difficult personalities, or blame patients for making their workdays difficult. The flip side of that coin is that it is difficult for a doctor to admit a mistake, as with the dentist who pulled the wrong tooth. Having a profession that does not give room for errors limits the dentist's options. In blaming the patient for having indicated the wrong tooth, her professionalism cannot easily be challenged. Pointing back to chapter 2 it is important to remember that the hierarchies we find in the Ecuadorian health care system is intrinsic to biomedicine in general, and not cultural specific. I argue however that the cultural acceptance of social inequalities makes the professional hierarchies more prominent than in cultures, such as the Norwegian, where equality is valued.

[78] Some of the communities have carbon filters in their water tubes provided by the NGO I worked with and the local parish. This is ineffective as people still connect and disconnect the tubes further down.

Concluding remarks

In this chapter we have seen how inequalities are naturalized in Ecuador, and how they are played out in a health care setting. I have focused on social hierarchies based on the "race" concept and on education and professionalism. Both the Kichwas themselves and the mestizos have traditionally perceived of indigenous people as inferior. However, ethnic identity is fluid, and often dependent upon factors such as language, clothing, education and wealth as well as physical attributes (Stark 1981). Social mobility is often associated with ridding oneself of indigenous attributes (Price 2003, Leinaweaver 2008), such as Dr. D who moved to the U.S. and became a doctor. The fact that more and more people with indigenous heritage get high status and well-paid jobs, coupled with a state effort to reduce marginalization, has been a positive development. At the same time mestizos have developed a fear of losing their own position in society and utilize a "discourse of reverse racism" (Hale 2006) to try and limit indigenous social mobility.

Professional hierarchies naturalize an unequal relationship between doctor and patient. I have shown various examples of how this plays out in Toa, were the doctor decides the rules and frequently scolds patients for asking the wrong questions or arriving at an inconvenient time. Many Toas are in bad health. Living in poverty puts severe strain on their bodies, and the same poverty does not allow them to be sick. Apart from the obvious fact that poverty and poor health is closely connected, the way peoples' actual needs are ignored becomes possible when marginalization is naturalized as it to a large degree is in Ecuador. The discourse of doctors and visiting health agents is that indigenous culture prevents people from taking care of themselves and understanding how to improve their health. Faced with this discrimination and injustice it seems only natural that the Toas are skeptical to an "outsider" doctor. In the next chapter the attention will be turned to the *auxiliares de enfermería* (nursing assistants) effort to diminish skepticism towards biomedicine and reducing the social gaps between doctor and patients.

Chapter 5

Mediating health care: the role of *auxiliares de enfermería*

Introduction

In the previous chapters we have seen the multiple reasons to why health care is problematic in Toa. We have seen how low status and priority is given to rural areas, and the consequential frustrations of both health personnel and patients. In chapter 3 a presentation of Andean medicine showed local conceptualizations of health and health care. I argue that the *auxiliares de enfermería* (nursing assistants, hereafter *auxiliares*) mediate between different conceptualizations of health and treatment when they explain biomedicine in a way which culturally makes sense to the patient. In addition they are the only health agents who address the patients wish and need to be taken care of personally and socially.

The *auxiliares* do work that the doctor does not have time to, such as vaccinating people in their homes, and in this way the *auxiliares* extends towards the patients from the doctors (or the biomedical) perspective. On the other hand they do promotion work in the communities, encouraging patients to seek biomedical help, and thus start the bridging towards biomedicine from the patients perspective. This chapter builds on previous discussions to present the important mediating role of the *auxiliares* in rural health care which will be presented in this chapter. I focus mainly on the *auxiliares*, but the reader should note that the TAP (primary care technicians)-students fill many of the same functions[79], and their role at the clinics and in the communities are in many ways similar to that of the *auxiliares*. The focus on the

[79] While *auxiliares* are not mentioned specifically, it is stated in MAIS (2012) that in rural areas there should be 1 TAP per 1500 residents. The TAPs should work in their communities of origin, where they are chosen, and perform their activities.

auxiliares is not an attempt to simplify ethnographic material, but a conscious choice reflecting the TAPs' position as young students and an intention to not speculate on what their role will be once they have completed their education. Before analyzing the role of the *auxiliares*, I wish to present how, even though the doctor often seems opposed to, and judgmental of, Andean medicine, the reality is more complex.

Blurred lines

Before starting a discussion on how the *auxiliares* mediate between biomedical and local conceptualizations and expectations of health care, it needs to be stated that the doctor was not was always dismissive of traditional medicine. Towards the end of fieldwork one of the TAPs, Ricardo, had filled out a form with a pregnant woman (23) about where and how she wanted to give birth, who she wanted present, and what she needed. This was done so that the health professionals could get an overview and to ensure that the woman had thought through her options. A week later when the woman came to the Thursday clinic for her week 33 control it became clear that she wanted to give birth at home even though the form stated the hospital as her first choice. "*I always give birth at home*" she said. As it turned out, she had told Ricardo that if there were any problems during labor she would go to the hospital, as she had done with her first child. It seemed likely that Ricardo knew *doctora* Andrea's preference for hospital births and had wanted to please her by presenting the woman as open to try it (if only as a last resort). In the end *doctora* Andrea changed the form so that it stated that the patient wanted to give birth at home. She also made her sign a statement that the doctor had explained all the dangers involving home birth (which she had not) and still refused to give birth at the hospital. With a new law being passed which allowed patients to sue their doctors (with a maximum penalty of five years in prison) for malpractice resulting in death, it became increasingly important for the doctor to get written statements when the patients wanted something else than what was officially recommended.

But Andrea was not completely opposed to traditional care. She herself had sought out a *yachak* to help her get rid of stress, and stated it worked well. She also recognized the competence of *parteras* (traditional midwives). Once a woman and her husband came in to the Tuesday clinic because they thought the baby lay too much to one side in the womb. They wanted the doctor's permission to see a *partera* who could "accommodate it". Andrea

professed her worries that applying too much pressure on the baby's tiny bones could cause them to break. She advised against it, but ultimately recognized that it was the parents' decision. "*I have seen the* parteras' *skill with my own eyes*" she said. Then she told a story of a 17 year old soon-to-be mother who had come in to the clinic (in a southern community where she used to work) with the baby's hand already out of its mother. *Doctora* Andrea recognized her own limitation in handling such a complicated birth, thought a caesarian section would be the only choice and called for an ambulance. But the baby did not care to wait for the ambulance and the situation started to become critical. One of the *auxiliares de enfermería* approached the doctor and said "*I am trained as a* partera, *will you please let me do what I do?"* "*At that time I didn't see how it could hurt*" *Doctora* Andrea continued her story. The *auxiliar* had put her hands on the belly, moved the baby around, gently pushed the hand back in, moved the baby around a bit more, and the child was born normally while still waiting for the ambulance.

What the above cases show is that although *doctora* Andrea believes biomedicine to be the best option for her patients, she recognizes some efficiency in Andean medicine. She also allows her patients to make decisions regarding their own health, even when she disagrees. When she finds her patients to be "intelligent" or "educated", the agency she allows them is greater. In the case where the couple wanted to "accommodate" the baby, she engaged in a calm dialogue with her patients, asked them what they wanted and why, explained her recommendations, but allowed the decision to be theirs. My impression is that when patients display "mestizo" attributes (speak Spanish fluently, are educated, have paid employment, have lived in a city for a while etc.) *doctora* Andrea is more inclined to engage in dialogs and listen to the patients' wishes with reason, not judgment. When patients possess none of the attributes she herself values, her attitude towards them is different. *Doctora* Andrea often gives up on the patients, gets annoyed with them, rolls her eyes and vocally taunts their beliefs and wishes. At times the doctor talks over the patient's heads saying they need to see a specialist in the city, but she knows they will never do it, so it is best they sign a document in case they die and she will be sent to prison. In these cases there is a need for mediators who understand both perspectives, and who speak both Spanish and the local language. Currently in Toa, this role is filled by the *auxiliares de enfermería*.

Who are the *auxiliares*?

Not a lot has been written on the *auxiliares* and even the newest health law (MAIS) does not say specifically who they are or what they do. In my search for information about the *auxiliares* I found a master's thesis from Ecuador which focused specifically on their training. Since there is limited access to information, I had to rely on the thesis for an overview of the *auxiliares*' job description. Here it was made clear that the role of the nursing assistant varies greatly with their place of employment. In hospitals, the *auxiliar* mainly prepares equipment, gets the patient ready for surgery and makes the patient's bed. In contrast, in rural areas they "collaborate with the doctor (…) to develop the community [and] realize nursing activities as part of various programs as stated by the national health plan" (García Loor 2005:53, my translation). From this I infer that in areas with a shortage of adequately educated personnel, the nursing assistants have to take on a wider range of tasks.

The three *auxiliares* who worked in Toa grew up in the community and when they started working in 1984 they had only a few courses in addition to seven years of primary school. Additional courses, e.g. in vaccination have been completed while working, and two of them also have completed high school. Their biomedical skills were insufficient to man the clinics alone, and they often had to call the doctor for advice. Their presence at the clinic was nevertheless important because the patients got access to rudimentary care on days when the doctor was occupied in other communities. The *auxiliares* were also important as assistants for the doctor, and interpreters. Furthermore, it was often they who "found" the sick or the recently pregnant during their door to door rounds in the communities, and persuaded them to visit the clinic. They worked to portray biomedical treatment as something important and desirable, and were unquestionably instrumental in getting people to show up at the clinics. It was also the *auxiliares* who ran the large vaccination campaign against the swine flu epidemic in November and December. They also informed patients of the opening hours and what was offered at the clinics (e.g. vaccinations) and at special health campaigns (e.g. the health fair, visiting gynecologist or ophthalmologists). Equally important, they were appreciated as advisors. As they walk around in the communities on a daily basis they are well known by everyone and people tend to open up to them about social and private problems, violent husbands, alcohol abuse, depression and the like. I will argue that the *auxiliares*' behavior towards patients in this aspect resembles that of the *yachaks*, and that their presence at the clinics therefore familiarizes biomedicine for many people.

Comparing *Auxiliares de Enfermería* to Assistant Nurses and Community Health Workers in other countries

An *auxiliar de enfermería* or nursing assistant is a local layperson with basic training in biomedicine. As mentioned, little has been written on them from the Andes, so to try and understand their role I had to look for comparisons. This kind of health agent is present at clinics in many countries, although their role in the community might vary. I quickly realized that their positive role as trusted community members and medical mediators was more similar to the role of Community Health Workers than other nursing assistants/medical attendants. In many African countries, such as Tanzania, medical attendants and are generally not very popular among patients, and sometimes their practice is dangerous. They man the health clinics when doctors are otherwise occupied. Often they fear to disturb the doctor and therefore avoid recognizing their own limitations and asking for advice. Many people feel they get second rate treatment if they are examined or treated by a medical attendant (Siri Lange, personal communication). In Ecuador the situation was different. Many patients, especially the elderly valued the *auxiliares* as medical authorities. When the *auxiliares* were in doubt, they called the doctor, and thus could treat common ailments, such as diarrhea in a safe way. However it is important to note that the *auxiliares* never substituted the doctor, but complemented her work. If the patient needed to see a doctor the *auxiliares* would ask them to come back. In some urgent cases, Marta used her car to drive patients to the clinic were the doctor worked, or the *Seguro* (peasants' social insurance) – clinic, if that was closer and the patient was insured.

As the *auxiliares* are health agents within their own communities, this gives them a local grounding which not all nursing assistants have. In Nepal for example assistant nurse-midwives are recruited among young, urban women, who face social and cultural challenges when they arrive in rural areas (Justice 1984). Young women are not seen as experienced enough to assist other women in child birth, and it is culturally unacceptable for them to live alone, and work in an all-male environment, which is often the case at Nepalese health clinics (ibid). Looking at the examples from Tanzania and Nepal shows that the *auxiliares* are set apart from other health agents within the same category.

Apart from their mediating function, which will be elaborated on shortly, the most important work the *auxiliares* do is promoting treatment and preventing disease in their own communities. Their role is therefore similar to that of Community Health Workers, an umbrella term encompassing health agents who:

> [S]hould be members of the communities where they work, should be selected by the communities, should be answerable to the communities for their activities, should be supported by the health system but not necessarily part of its organization, and have shorter training than professional workers (WHO Study Group 1989, in Lehman and Sanders 2007:3)

The *auxiliares de enfermería* in Toa do not fall into the classification of a Community Health Worker as they had basic but certificated biomedical training and were permanently employed and paid by the ministry of public health. The definition nevertheless fits in that a low-income-country use "community members to render certain basic health services to the communities they come from" as a "strategy to address the growing shortage of health workers" (Lehman and Sanders 2007:v) . A short comparison to the Brazilian Sistema Unico de Saúde (Unified Health System) can be useful. The Brazilian system is largely reckoned as the most successful Community Health Worker program in the world to date, partly because the CHWs are recruited locally and paid decently by local standards (Lehman and Sanders 2007). Here "Primary Care teams are composed of a doctor, a nurse, a nurse auxiliary, and at least four Community Health Workers (CHWs), recruited from the local community and who are responsible for up to 750 people" (Johnson, Noyes et al. 2013:1). While in Ecuador the *auxiliares* and TAP-students visit every single household unsolicited, this task is performed by the community health workers and not the nurse auxiliaries in Brazil (ibid). Both the Brazilian community health workers and the Toan *auxiliares* are paid to work in their own communities, and they visit the patients in their homes to do health promotion and disease prevention[80].

[80] As mentioned, I have not found a formal job description, and neither have any comparative examples to show if the *auxiliares* in other parts of Ecuador worked in a similar way as those in Toa. For example, at the *Seguro* clinic, the *auxiliar* was an assistant to the doctor and dentist, and mainly did paper work.

The *auxiliar* as assistant and interpreter

> [T]he worldviews, opinions, and judgment of professionals tend to differ significantly from the worldviews, opinions, and judgment of their clients. Professionals are often unaware of this gap between their views and that of their clients. Health care staff tends to think that patients think like themselves" (Grimen 2009:21)

> Although doctor and patients sometimes used the same words in communicating with each other, each was almost completely ignorant of the other's often very specific meanings (Scheper-Hughes 1992:205f)

The above quotes show how in a setting largely defined on professional hierarchies, differences in knowledge are not sufficiently addressed. When language barriers are added, misunderstandings and frustrations are bound to arise. Earlier in this thesis I have shown that the doctor in Toa frequently got annoyed at her patients "ignorance", at times even when they tried to please her. As Moss and Roberts have shown, when patients are not fluent in the doctor's language they are unable to control how they are perceived (2005). This can naturally lead to misunderstandings and word choices and intonation may, in the Toan case, not include the level of respect the doctor expects. With the case of Bangladeshi diabetes patients in the United Kingdom it has been shown that interpreters sometimes sensor what they translate (Seale, Rivas et al. 2013). At times they conceal the nurse's judgment of patients not taking their medication, they make excuses for the patients, or they may leave out patients' worries about e.g. loosing too much blood when measuring the sugar level. In that way interpreters function as moral mediators (ibid). Because of my limited understanding of Kichwa it is difficult to assess whether this was true in the cases where the *auxiliares* or TAP-student translated at the health clinics in Toa. What I do know, however, is that they often argued on behalf of the patients. The reader will remember the old lady who was refused by the doctor on the grounds that she came too late, and the doctor was now otherwise engaged. It was the effort of the TAP-student, the *auxiliar* and the driver (also from Toa) that in the end swayed the doctor to attend her (however inadequate and brief it was).

Caring for the whole person

Drawing on the previous discussions I wish to argue that one of the main differences between biomedicine and Andean medicine is that the former is highly specialized while the latter is holistic. While biomedicine often is portrayed as separated from religion, moral and politics (Hahn and Kleinman 1983), Andean healers specifically utilize both religion and morals to diagnose and cure their patients. McKee (2003) pointed to the curing of children with *mal aire* (illness from evil winds) as a form of enculturation. The diagnosis in itself was a way of morally guiding the parents, since the father's drunkenness was pointed to as indirectly causing the daughters illness. Further we have seen that Andean healers often call upon both the magical landscape and the Christian God to heal their patients (see e.g. Gutman 1998, Quintero and Roulet 2006). By calling Andean medicine holistic I mean that health is conceptualized as something not only related to the individual, but also to community, family, economy and the supernatural. While it is recognized in biomedicine that the social and natural environment has an effect on the patient, Andean medicine goes further in including these factors in diagnosis and treatment. *Susto* (fright) from e.g. falling out of bed might cause a child to lose its soul and ultimately die if not treated (Crandon 1983, Price 2003). Children are less likely to be struck by *susto* or *mal aire* if they are surrounded by family (McKee 2003), and through diagnosis and treatment the healer thus has the opportunity to influence the parents' child rearing. I point to a holistic approach as a trait of Andean Medicine, and do not intend to imply that all indigenous medicines are necessarily holistic. For example Waldram has shown from the Q'eqchi in Belize that even if the issue is psychological or social the "root of the problem is always organic or spiritual" (2012:201). The Q'eqchi way of narrowing down etiology is more similar to biomedicine than the Andean healers' intent to ameliorate social and personal relationships as an integral part of the healing. Furthermore, healers in Belize often interact minimally with their patients, with an average treatment time of only 6,5 minutes. A short consultation excludes the possibility for long conversations, a trait that is typical in Andean medicine. To illustrate, Crandon-Malamud (1993) writes that when a *yatiri* (Bolivian healer, similar to the *yachak*) came to heal her, he spent two hours eating, and talking to her translator before even addressing her as a patient. There are clearly large differences in indigenous healing systems, also within Latin America.

In the previous chapter I showed that biomedical doctors and visiting health agents frequently accused Toan patients of not taking proper care of their own hygiene and health. A frequent

discourse was also that the Toas' "culture" prevented them of making positive changes. This stigmatizing attitude from doctors and visiting health agents shows tendencies to focus on treating symptoms rather than causes. I exemplified this with how medicines against parasites were routinely given every 6 months, while nothing was done with the water supply. It should also be remembered that what patients consider the cause of their illness might differ from the doctor's perception, which again mystifies the treatment. I showed this in the case where a young girl feels a pain in her heart (which of course could have emotional undertones) and get sent home with vitamin B injections. We should also take care not to forget that structural reasons for communal sickness are equally frustrating for the doctor who sees the underlying problems but is unable to address them. Unfortunately, the patients only perceive that the government has left them to construct their own water supply, and their doctor keep telling them that the same system is contaminated and dangerous for them. Social inequalities and structural violence thus leads to a double stigma towards poor, rural patients.

The shift from a holistic view of health to the more narrowly focused biomedical perspective in the Andes can be compared to the changes in welfare system of post-World War Two Hungary, as described by Lynne Haney (2002). Up until 1968 a Hungarian mother could be perceived as in need on several levels. She met a welfare system that took seriously her need to find the child's father, to find a job, housing and to solicit support from her extended kin (ibid). A generation later a woman's need was defined largely by her role as a mother, and getting maternity leave was seen as sufficient help. After 1985 the focus shifted again, this time to what Haney calls a neoliberal approach to welfare, where those seeking it were classified as worthy or unworthy recipients based on their income and assets alone (ibid). The previous regard for the whole person and her unique circumstances had thus been significantly narrowed down to a question of monetary support. For the women seeking welfare this was confusing and they did not know what to expect from the people that they saw as supposed to help them.

In the previous chapters we have seen that in Toa, the change from Andean medicine to biomedicine, in addition to hierarchical differences between doctors and patients has resulted in a situation where patients, although wanting and seeing a need for biomedicine, are highly skeptical. While the Andean forms of healing involve attention to the whole person and their unique circumstances, much like the Soviet-era Hungarian welfare system, biomedicine has a much more narrow focus on the individual body. Just like the shift Hungarian women experienced when seeking welfare assistance, patients in Toa find that the biomedical

personnel offer them something other, and narrower, than what their previous experience have led them to expect from a healer. As they learned to expect less personal care from the doctor, many emphasized the quick pain alleviation from medicines as a positive aspect of biomedicine. Yet, the Toas still wanted to feel like they mattered to the doctor. Paradoxically the doctor complained about patients only wanting medicines just as much as the patients complained about the doctor only *giving out* medicines. The result was that patients looked to the *auxiliares de enfermería* (nursing assistants) who interact with the patients in a holistic matter. The display personal care and interest in social history, therefore their behavior is similar to the way a *yachak* or *curandero* would behave. María, the *auxiliar* at the Monday and Friday clinics once told me that "*what is most important for them [the patients] is to be treated well*". The following examples will show in which ways the *auxiliares* work to "treat their patients well" and how, when the doctor does not, their presence at the clinics is important.

The social role of the *auxiliares*

The 12th of November[81] the national vaccination campaign in response to the AH1N1 pandemic, commonly known as swine flu, was initiated in Toa. María, the nursing assistant responsible for the Monday and Friday clinics brought me along on her rounds. We hitched a ride with a passing *camioneta* (pick-up truck) some 15 minutes up a hill to the edge of Toa. We got off in a cobble stone street surrounded by two meter brick and *kamkawa* (K- hard soil) walls. We were to visit an old and ill woman, and when we yelled outside the gate her brother came out to meet us. María introduced me and told him that we were doing a vaccination campaign for the Ministry of Public Health (Ministerio de Salud Publica, hereafter MSP). He explained that thanks to God he had never been ill and with His protection he did not need any vaccination. María was expected to convince him to get the vaccine but she also shared his religion and culture, and did not want to challenge his faith. Without directly contradicting him she explained that often people did not take care of themselves and their hygiene, and that vaccination was a way of protecting both themselves and their neighbors. Even though she was unable to convince him, this case is important to understand why the *auxiliares* are crucial in delivering biomedical health care in Toa. The way she spoke was instrumental to

[81] The national campaign started November 11th, the same day as the health fair in Toa. The door to door campaign thus started one day later.

not further alienate him from biomedicine. Firstly, and very importantly, her grammar included herself, so that she did not scold the man for lacking personal care and hygiene, but presented it as a flaw of humanity, thus framing it within Christian discourse. Secondly, in saying that a vaccine also protected neighbors from contamination, she played on Andean values of community solidarity and simultaneously avoided challenging his faith in personal protection from God. I argue that this is precisely the kind of cultural sensitivity which combined with biomedical knowledge is vital in promoting health care, and it is something the mestizo doctors unfortunately lacked.

While we were speaking to the first man and trying to convince him to be vaccinated and let us vaccinate his sister, a couple stopped on their way down from their field. The woman started talking about their aggressive teenage son. She sobbed when she related how he would not even listen to their priest. María listened patiently and advised them to read the Bible carefully and find answers there. When we left we had spent almost an hour talking mostly about religion in health and child rearing, and no one wanted the vaccine.

As mentioned, Andean healing has a social and moral aspect to it. I will argue that the fact that María frequently was asked to give advice, and always did so when asked (even though the issues where far beyond the realm of medicine) is a resemblance to the social authority *yachaks* traditionally held, and thus contributed to her own authority in the community.

Reciprocity

Reciprocity is one of the most important social ideals in Andean community (Bastien 1982). The reciprocal relations is often not between individuals but between their families and communities (Bastien 1982:799)[82]. Bastien states that the problem with biomedicine in rural communities is not "the *content* of western biomedicine but the way it is delivered which threatens the basic economic and social fibers of Andean culture" (1982:795, original emphasis). Bastien argues that biomedicine and Andean medicine can coexist and learn from each other. He argues that Andeans want biomedical care, but are uncomfortable with the way it is delivered to them (Bastien 1982). This is highly consistent with my own material, and precisely why I argue it is of utter importance to employ local people, such as the *auxiliares*.

[82] The Kichwa word *ayllu* can mean family, community or village, depending on the context, but also points to how the Kichwas not necessarily distinguish between these.

The *auxiliares* were paid by the Ministry of Public Health (MSP) and all services at the clinics were free. Yet they still operated to an extent within local reciprocal systems, which sometimes hindered the *auxiliares* in their work. One of the last days in the field I walked with María as usual and we stopped by an old lady who was harvesting potatoes. María vaccinated her and also listen to all her worries about her migrated sons, her granddaughter who were about to marry and a family land dispute. Before we left she insisted on giving us potatoes. I declined politely by saying that I was leaving in a couple of days and still had too many potatoes. María was given a sack of probably almost ten kilos. The weight of it made it impossible for us to continue that day's work. It could be argued that accepting such gifts is corruption, but it can also be seen as an integral part of treatment efficiency. In the Andes, when a curer heals someone, or vaccinates as in this case, "he receives produce and/or an obligation (*ayni*) on the part of the sick person (or his family) to do something for the curer (or his family)" (Bastien 1982). By allowing the patients to show their gratitude and by playing within the system María strengthened ties of confidence which would ease her future work. Mauss (1954) have described the three duties of the gift, to give, receive, and to reciprocate. Giving gifts establishes social, political and economic bonds, and refusing, or failing to reciprocate is to deny such bonds. As long as the doctor in Toa gives out free treatment and medication, she will never form reciprocal bonds with the Toas. When the *auxiliares* form such bonds, by extension they form bonds between biomedicine and the community. Through reciprocal relations the *auxiliares* establish trust and familiarity with biomedicine, as well as building up under their own medical authority.

Auxiliares as medical authorities

To a larger extent than the doctor the *auxiliares* allowed themselves to take the time the patients needed - even when the conversation strayed far from the point and purpose of their visit. As presented in chapter 3, traditional healers often talk about everything *but* the patient and the illness when setting a diagnosis and also when curing (Greenway 2003). As Andeans attribute illnesses to external social and communitarian causes, small talk may very well have a specific function. That *auxiliares* status as medical authorities in the communities was enhanced by the fact that they always listened to what the Toas wanted to tell them, and knew the personal and social history of each individual. This authority was visible at the clinics as patients often checked with the *auxiliares* before leaving the clinics. The doctor complained

that her patients "*always wanted a second consultation*". Part of the reason why many wanted this was that they did not speak Spanish very well and was afraid to test the doctor's patience by making her go over things several times. Therefore they needed an extra consultation to be sure they knew how to take their medicines. Another explanation could be that they did not fully trust the doctor and needed the reassurance from a trusted person that the treatment the doctor recommended was in fact good for them. A third explanation could be that cultural and social differences makes doctor-patient communication difficult. Bastien, drawing on Levi-Strauss writes that "[f]or the transference of information (…) there must be cross-over of knowledge from the structural-cognitive system of the change agent to that of the recipient" (Bastien 1987:1110). That is, they would to a certain degree need to belong to the same knowledge system. Bastien continues:

> Transfer of information from doctors necessitates that the change item is comprehended and cognitively functional within thought patterns of peasants. Many [Bolivian] doctors are capable of doing this because of their Andean ancestry, but they are unwilling because they have been taught to replace traditional medicine with modern [biomedical] medicine (Bastien 1987:1110)

What Bastien is saying is that biomedical doctors in the Andes often have the capacity to explain a diagnosis or a treatment in a way that culturally makes sense to the patients and thus enhances the probability that they will follow the doctor's advice. Previously we have seen that in Ecuador getting ahead is perceived as moving away from everything that is associated with the indigenous, and towards what is seen as European. This extends to the relationship between Andean medicine and biomedicine.

Drawing on Bastien I will argue that the doctors who have acquired a high status education perceive themselves as socially superior to their patients, and that this plays a part in avoiding to function within traditional Andean thought patterns. This points to the third reason why the patients often sought a "second consultation" with the *auxiliares*: The *auxiliares* possess significantly more biomedical knowledge than the patients, and are seen as medical authorities. That would increase the social distance between patients and *auxiliares*, and place the latter closer to the medical doctor on the social ladder. However their education is no longer than what is considered normal in Toa. It has become normal for teenagers to complete high school and some also enter universities. The biomedical training of the *auxiliares* therefor does not create a significant social distance. Further, they are paid minimum wage

($318 a month) and their economic status is within what the Toas consider normal. Operating within traditional systems of reciprocity, as shown above, further strengthens the *auxiliares*' social position in the communities. Being trained in biomedicine yet part of the same social and cultural universe, the *auxiliares* could present biomedical advice in a way that familiarized it to the patients. In a way they personified Bastien's call for a cross-over from the cognitive system of the change agent (the doctor) to the recipient (the patient). While the doctor told pregnant women they needed to see a gynecologist, the *auxiliares* and TAP-students explained that in the city there were doctors who specialized in women's health, and could use technology to ensure the baby was developing correctly. The message was the same, but while the former made the patient skeptical to make the trip for something she did not understand what was, or why she needed, the second presentation seemed more assuring.

The doctor expected the patient have the same reference base as herself; that is being familiar with what gynecologists are and do. When the patient did not, she interpreted the patient's skepticism as a protest to follow biomedical advice, and thus created unnecessary conflict. The TAP-student on the other hand explained carefully in the patient's own language that it was recommended to see a gynecologist, and why it was so. It is easier to get a person to follow advice if they understand what exactly they are being advised to do, and why. In Toa, the *auxiliares* and the TAPs were the only ones willing to make such explication. We have also seen that during the AH1N1 vaccination campaign María presented the need for vaccination as a way of counteracting human flaws and securing the health of the entire community. Sharing the social and cultural world of the patients, the *auxiliares* were capable of assessing how biomedical information could most easily be transferred. When the patients got a "second consultation" they therefore did not only get a repetition in their own language of the doctor's advice, but a culturally and socially adapted explanation of why they should choose to follow that advice.

Concluding remarks

It will be extremely simplistic to argue that patients based their decision to seek biomedical health care only on the advice and presence of the *auxiliares*. However, I will argue that the *auxiliares* helped make biomedicine a more obvious choice for rural patients. As mentioned several times biomedicine was fairly recently introduced to Toa. Even before 1984 the health care system was probably pluralistic as has been shown from all over the Andes with *curanderos, fregadores, parteras* and *yachaks*. In the last 29 years people have learned what to expect from biomedicine and incorporated its practices into their health seeking behavior. As mentioned in chapter 2, people decide in the private sphere, at home, when they are ill and what kind of response that illness requires. Many ailments are thought to be best treated by biomedical doctor and especially by chemical medicine. At the same time, people get disappointed when medicines are all they get. What they want is for the doctor to recognize their holistic way of understanding illness. For the patients, a pill may treat symptoms but never the cause, as causes are seen as external and non-biological. Bastien argues that biomedical care could me more successful if the doctor would treat patients in their homes, near their relatives, and acknowledge the Andeans social etiologies (1982:800). As long as that does not happen, it is important that there are professionals (the *auxiliares*) who do.

Summary and ways forward

In this thesis I have presented public health care in a rural community situated in the central Ecuadorian Highlands. Toa was chosen as a fieldsite because it is known in Ecuador for a strong indigenous culture, with locally elected leaders and a proud history as the center of the pre-Incan Puruwá kingdom. I was interested in the interface between tradition and modernity and Toa fit perfectly as a research site because of its closeness to Riobamba, a relatively large city and province capital of Chimborazo.

Throughout the thesis I have provided examples of how public health care works in Toa, how people conceptualize health and sickness and the role of traditional medicine in modern day Ecuador. I have looked into the marginalization of the indigenous, poor and uneducated. In a health care situation the patient is already vulnerable, and therefore particularly sensitive to discrimination. However the last chapter ended on a positive note, showing how local *auxiliares de enfermería* mediate between conceptualizations and people. In this last section I want to turn the gaze forward, and see how my thesis can contribute to existing research and propose some new directions for medical anthropology in the Andes. Before doing that however I wish to remind the reader of my main findings.

The biomedical coverage of rural areas in Ecuador is inadequate. Rural areas have never been prioritized in Ecuadorian health care and are often served by recent graduates, *rurales*. The *rurales* frequently view their year of provincial service after medicine school as a waste of time, but even if they are motivated, lacking equipment and bad relations with the patients often discourage them (Bastien 1987). The situation in Toa is no better. *Rurales* has come and gone since the introduction of biomedicine in 1984, and medical coverage is unstable. *Doctora* Andrea who is the first doctor to work on a three year contract needs to rotate between five clinics, after the last *rural* finished his period in spring 2013, thus leaving the clinics served by *auxiliares* with only rudimentary training. The clinics in Toa are poorly equipped, patient's files are not digitalized and both equipment and papers are frequently lost.

Further we saw how Toa is a frustrating work place. In addition to the above mentioned problems, the medical team has to work with a group of patients where a large portion neither understands their language nor the basic premises of biomedicine. Building trust is difficult. I showed how the dentist was blamed for causing cancer after a tumor became visible when she pulled a molar. The skepticism towards the doctors and biomedicine in general makes many patients hesitate to seek out health care and the medical team has to look for them in their houses and their fields. The doctor has many demands on her time and having to search for patients who she feels do not appreciate her services is a major cause of frustration.

In chapter three I showed that how Andeans conceptualize health and sickness differs from the biomedical model. Biomedicine is centered around human biology and pathophysiology (Hahn and Kleinman 1983). Andeans on the other hand believe imbalances to be underlying reasons for sickness (del Pozo 2005). Such imbalances can be between hot and cold properties, in social and reciprocal relations, or disturbed relations with a supernatural landscape and the Christian God. In the Andes illness may be caused by a frightening experience (*susto*), evil winds (*mal aire*) and malignant looks (*mal ojo*) or to be rooted in social conflict resulting in emotional distress e.g. sadness (*pena),* stress/worry (nervios) and anger (*iras/colerín*) (see e.g. Miles and Leatherman 2003). The medical system they have developed to deal with such illnesses therefore needs to be holistic in its approach. Another way biomedical and Andean understandings of health differ is in how the relation between food and health is conceptualized. While biomedicine builds upon scientific knowledge of micronutrients and vitamins, Andeans place primacy on the natural and on balancing hot and cold properties. The Andeans believe local foods, such as potatoes, are vital to health, while mestizo food, although prestigious can be harmful (Graham 2003). The local is valued to such a degree that nutritional programs are difficult to implement. "*Why eat broccoli when we have plenty of potatoes?"* was a common attitude in Toa.

One of the purposes of the discussion on Andean medicine was to show that what patients want and expect from health care is not what they get from biomedicine. The Toas want and expect their doctor to care about them at a personal level and be interested in their personal worries. Andean healers often address social relations when they set the diagnosis and through diagnosis and treatment they educate the patient and the patient's family in culture and morality (Greenway 2003, McKee 2003). Although Andean medicine has been revalued in recent years, it is becoming gradually "westernized". Paradoxically, the attractiveness of "natural" medicine increases when it is capitalized and marketed in the form of pills or

labeled tonic-bottles (Miles 1998). Further, we saw that urban hospitals such as the Hospital Andino have employed traditional practitioners and thus Andean medicine becomes incorporated into a professionalized domain traditionally reserved for biomedicine.

The power-relation between the biomedical and Andean healing modalities is hierarchical with the former dominating the latter. The experience of this hierarchy is magnified by social inequalities. In chapter 4 I showed that marginalization is naturalized in Ecuador. Ethnicity is a social-historical construct and ethnical boundaries are negotiable (Stark 1981, Stolcke 1993). In Ecuador there is a high degree of racial ambivalence. While marginalization follows old "race" lines (where the classification of "race" is largely based on physical appearance) one can still attain social mobility by ridding oneself of indigenous attributes (Price 2003, Leinaweaver 2008). Social discrimination follow the line of dichotomies (young – old, female – male, uneducated – educated, poor – rich, rural – urban, Kichwa – Spanish, indigenous – white) and consistently places patients in a disadvantaged position relative to the doctor. While the latter possess all the valued attributes, the former often possess none. Social marginalization makes it possible for the doctors and other health professionals to blame the Toas sickness on the patients themselves and their culture. As has been shown by others, being healthy is increasingly seen as a personal responsibility (Dumit 2012), rather than a result of poverty and structural violence (Scheper-Hughes 1992).

Many of the most common ailments in Toa are direct results of poverty. The hard agricultural labor put severe strain on the peasants' bodies and many suffer from back pain and hernia. The cold climate contributes to the high prevalence of arthritis, and everyone suffers from parasites because of unsafe drinking water. People lack access to cash, and sustain themselves to a large degree by what they produce for consumption. The harsh climate and high altitude put severe limitations on what can be produced and the Toas therefore rely on a diet which is high in energy (carbohydrates) put low in protein, vitamins and iron. There is always food, yet many suffer from chronic malnutrition.

The Toas are being blamed for having something intrinsic in their culture that causes their destitution. This way of marginalizing the indigenous population is so common in Ecuador that the doctor find it reasonable to scold her patients for not taking care of themselves, rather than addressing their illness. A person who complains about stomach ache gets sent home with medicines against parasites, sometimes masking more severe diseases (such as in the

case with the young man who turned out to have a stomach ulcer). Many patients feel like the doctor do not care about them and only give out medicine.

In the last chapter I argued that the *auxiliares* contribute to making biomedicine a more obvious choice for rural patients. The *auxiliares de enfermería* mediate between biomedicine and Andean conceptualizations of health and sickness. They also mediate at a personal level between patients and the doctor. The *auxiliares* conceptually bring biomedicine to the patient by making it understandable and desirable. They also bring biomedicine to the patients in a physical sense by doing door-to-door vaccination campaigns. On their rounds in the communities they encourage patients to show up at the clinics, and in that way physically bring the Toas to the doctor, and by extension biomedicine. In chapter 2 I showed that there are many conflicts between the doctor and the *auxiliares*. Still, the *auxiliares* risk further conflict by speaking the patient's case as we saw with the old woman who was sent away for having showed up too late.

The *auxiliares* are trusted as medical authorities because they approach their patients' health in a holistic matter and play within traditional systems of reciprocity. Bastien has showed that the way biomedicine is delivered in indigenous communities "threatens the basic economic and social fibers of Andean culture" (1982:795). I argue that the *auxiliares* deliver biomedicine in a way that strengthens economic and social fibers, and ensures that biomedicine makes sense within local culture. A good example of this was how, during the vaccination campaign, María managed to utilize traditional values of taking care of the community and a Christian discourse of all human beings as flawed to make the vaccine desirable. Receiving gifts and listening to personal worries strengthen social ties which again increases patients' experience of being cared for. As the title of this thesis states all the patients want is to be treated well, yet they are met with discrimination from their doctor, and diagnoses and treatments which make no sense to them. To build bridges and trust between patients and doctors and by extension Andean conceptualizations of health and biomedical disease models I argue that it is important to employ local health agents. In Toa the *auxiliares* are the translators, mediators, caretakers and medical authorities. Through the work of the *auxiliares de enfermería* biomedicine becomes culturally and socially meaningful for indigenous patients.

The questions that remain are where do we stand, and what are the ways forward? Throughout this thesis I have followed a critical approach looking at how social, political and economic

factors influence public health in Toa. I found that while medical pluralism is highly prevalent on a conceptual level, in practice biomedicine dominates health care. My main contribution to anthropological research in the region is the identification of the *auxiliares de enfermería* (nursing assistants) as key agents in translating between local conceptualizations of health and biomedical practice. However further research is needed to keep up with a rapidly changing medical world. When Andeans gradually lose traditional healers as moral guides, and healing as a form of enculturation disappears - their stock of knowledge changes. Following Barth (2002) who largely equates a groups shared knowledge, way of transmitting it and the social organization around it with the anthropological notion of culture an enormously important question arise: When Andeans knowledge changes what happens to their culture? Is biomedicine a threat to Andean culture as Bastien suggests?

Further research is needed to address the question of how to deliver health care in an exclusively positive manner. The United Nations are now in the midst of creating new post-2015 development goals. I see it as anthropology's task to make sure the direction of new development policies encompasses the importance of cultural sensitivity. Previous development goals emphasized the eradication of hunger (MDG 1), the reduction of child mortality (MDG 4) and improved maternal health (MDG 5) (UN 2014b). It is now time to look farther. In Toa people were not hungry, and increasingly people were becoming obese and in risk of diabetes. We need research that address the statement "*Why plant broccoli that is foreign to us when we have plenty of potatoes?"* This points to how a diet which is central to cultural values can be an obstacle for reducing chronic malnutrition. Research is needed to find ways of unifying local and biomedical conceptualizations of health.

To conclude I wish to return to the first case I presented in the introduction. Normita followed biomedical advice. She gave birth at a hospital, allowed medical doctors to deliver her child in the way they found appropriate. Both mother and child returned safely to their homes. From a biomedical and development perspective Normita's story is one of success. Socially and culturally however it was catastrophic. Her cesarean section sent her mother into physical and psychological illness and caused upheaval and conflict within the family. In cases such as Normita's, mediators like the *auxiliares* are not present and have no influence. I call for research to address how to ensure success in developmental terms is also personal success. Health is a human right and cannot be loaded with cultural conflict.

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