

**NEGOTIATING HEALTH AND IDENTITY: PERUVIAN  
VILLAGERS' DISCOURSES ON THE UNEASY CO-  
EXISTENCE OF PRIMARY HEALTH CARE AND  
INDIGENOUS MEDICINE**

by

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B.A., University of Alberta, 2003

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## ABSTRACT

Global health care models in developing countries urge integration of indigenous medicine with Primary Health Care (PHC). Neoliberal constraints on PHC have contributed to revitalization of indigenous medicine among poor, rural people. Health workers, however, often view indigenous medicine as ineffective and primitive. This thesis shows how residents of a remote Peruvian village negotiate between biomedicine and local knowledge of medicinal plants to create a pluralistic healthscape. Villagers access a clinic that seeks to provide low cost health care through community participation for the poor and marginalized. While clinic workers foster cultural sensitivity when treating their patients, villagers favour indigenous medicine over modern pharmaceuticals. Villagers' discourses concerning health care choices offer insights into social and cultural processes beyond the medical. They tell us about the revitalization of Andean identity, the conflictual relationship that villagers have with modernity, and how they wish to subvert power that western medicine has over them.

## **DEDICATION**

In memory of my father, Russell James Gold (1949 – 2005).

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# Chapter 1: Introduction

## 1.1 Introduction

Before, our grandparents cured themselves naturally with herbs, but now, since the Ministry of Health has appeared, they obligated everyone to come to the clinic to be cured. If we didn't go, and if someone in the community died, there would be a fine to pay, and if you didn't pay the fine, you weren't allowed to bury the deceased. With this, everyone lost this tool [of using natural herbs], and instead go to the clinic. But recently we have been reviving our plants, and we are curing ourselves [with our plants]. Of course, our parents told us [plants] were good, but we were not interested, it was better that we just went to the clinic or to the hospital. But now, recently, people are realizing<sup>1</sup> (Interview 101a).

This quotation came from one of my informants from the *comunidad campesino* (rural community) of Añawi<sup>2</sup> in the Andes in Perú. It gives a brief perspective of the history of health seeking in this community and the presence of Primary Health Care (PHC), an international initiative, in their region. The quotation encapsulates the key themes that are addressed in this thesis, which examines the interstices between PHC and indigenous medical systems and explores the interactions that occur between them at the local scale.

Despite the advances that development has brought to many countries in the so-called 'third world', an overall improvement in the condition of people's health and their living and working environments has not occurred (Pederson & Coloma 1983, Wayland

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<sup>1</sup> *Antes nuestros abuelos curaban con las hierbas naturalmente, pero después ha aparecido el Ministerio de Salud y así avanzado entonces, ya todos los compañeros de la comunidad les han obligado para que se vayan a consultar, hacer curar en la posta. Si no van, o de repente puede fallecer un compañero hay una multa – y si no lo paga, no lo puede enterar. Con eso ya, toda la gente ya se olvidado esa herramienta. Mejor se van a la posta. Pero recién estamos rescatando nuestras plants, y de nuevo estamos curando nosotros. Claro, nuestros padres dicen es bueno, y no nos interesaba ya, mejor nos vamos a la posta consultar o sino al hospital. Pero ahora recién la gente se da cuenta ahora.*

<sup>2</sup> This, along with the names of my informants, is a pseudonym. Inhabitants of Añawi are referred to as Añawayans.

2001). For example, in Perú “epidemics of cholera and dengue fever...ever increasing rates of HIV/AIDS and...the development of multidrug-resistant strains of TB” (Miles & Leatherman 2003, 4) have accompanied the social and political changes. The processes and consequences of social polarization are increasingly evident in these countries. While specific diseases continue to be targeted by international bodies such as the World Bank and the World Health Organization (WHO), these campaigns have little consideration of *quality* of life issues. Although it can be argued that development has brought increased international attention to issues such as conservation, social justice, and health, a by-product of this attention is the imposition of hegemonic western cultural ideals. For example, western medical policies and initiatives are often parachuted, or transferred into places that have pre-existing culturally embedded medical systems. From its inception, Western medicine has perceived itself to be superior to alternative forms of medical care (Baer *et al.* 1997) and “clearly established hegemony over alternative medical systems” (Baer 2003, 46). Thus, while western medicine has indisputably made improvement to health, including increased longevity, decreased child mortality and the great reduction of many diseases, it has made little attempt to consider the positive elements of local medical systems. Additionally, considering that biomedicine is an expression of Western science, it represents a move towards progress and civilization for governments who adopt biomedical strategies (Madge 1998). Thus, such policies have been readily adopted by governments. However, while biomedical services have improved aspects of health care, they have led to the decline of local medical systems (Janes 1999). Consequently there are tensions and debates surrounding the delivery of health care in developing countries.

When people seek health care, not only are they seeking to treat their ill health, but they also enact meta-narratives that impart information about other aspects of their social

lives and culture beyond the medical (Conner 2004, Janes 1999, Wayland 2004).

Consequently, while this thesis tells a story through the lens of delivery of health care and the interfaces of medical systems, in a broader perspective it is about the processes of transculturation, the negotiation of culture and cultural identity and conflicting relationships with 'modernity'.

This research took place in the Peruvian Andes, near the city of Cusco in the Sacred Valley – a popular tourist destination point, and the gateway to the world famous archaeological site Machu Picchu. While Cusco itself is a city (albeit small) of cosmopolitan proportions, the indigenous people that live in the rural communities in the Sacred Valley are most often poor, subsistence-level peasants or *campesinos*<sup>3</sup>. Because they self-identify more as *campesinos* than as indigenous, I refer to them throughout my thesis as *campesinos*. The *campesinos* I interviewed have access to a primary health care (PHC) clinic based on western medicine, but for the most part rely on the long-standing lay knowledge of medicinal plants that has been passed down from previous generations. Recently they have become involved with a research institute (IEPLAM – *Instituto Ecológico de Plantas Medicinales*)<sup>4</sup> that teaches them about medicinal plants, while coaching them on the manufacture of medicinal plant products that they try to sell to local people, and eventually want to sell more extensively.

## 1.2 Terms and concepts

### 1.2.1 'Healthscape'

I am interested in the experiences of villagers operating between these contrasting institutions and worldviews while seeking to find solutions to health issues. I create the

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<sup>3</sup> *Campesino* in the Andes are commonly indigenous, but self identify more as *campesino* than indigenous.

<sup>4</sup> The Ecological Institute of Medicinal Plants

neologism 'healthscape' to refer to the space in which the seeking of health plays out, or the interstices between the various medical systems in which everyday 'health seeking' occur at the local level. The suffix '-scape' describes a view, scenery, or a picture or representation of such a view, as specified by the prefix, in this case, 'health'. The view is gazed on and articulated from the point of view of the user, in this case an indigenous minority. While the representation of their point of view is fraught with ethical difficulties, it is nevertheless developed with the postcolonial understanding that not only does the western 'gaze' on the indigenous, but there is also a reciprocal 'indigenous' gaze on the western. Too often the narratives concerning indigenous people's initial observations, encounters and experiences with primary health care are ignored when considering the influences of western health systems on localized health systems and indigenous people.

The term 'healthscape' borrows from Gesler's (1992) ideas of 'therapeutic landscapes' in the examination of the healing properties of actual places or situations. Madge (1998) builds on Gesler's idea and employs it in her study of medicinal plants in The Gambia to discuss the "specific health care beliefs, practices and experiences of a particular group of people located in a specific place" (p. 309). While I draw on the understanding of cultural geography's meaning of landscape as "a text to be read for what it says about human ideas and activity" (Gesler 1992, 736), I do not examine the healing property of the place itself, nor do I examine the *specific* beliefs, practices and experiences of a particular group of people. Rather I examine the interface of various medical techniques and systems at the local scale as influenced by factors at other scales. Furthermore, I focus on health seeking as *process* and *becoming* as opposed to a static, unchanging act.

### 1.2.2 'Curing' and 'healing'

Waldram (2000) describes *curing* as “a primarily biological process that emphasizes the removal of pathology or the repairing of physiological malfunctions, that is disease,” (p. 604) compared to *healing* which he describes as “a broader psychosocial process of repairing the affective, social, and spiritual dimensions of ill health or illness” (p. 604). Typically Añawayans treat ill health by using a variety of therapeutic options. The PHC clinic is in a neighbouring village, approximately 10 km away from Añawi. There is a variety of traditional medical practitioners in the region, but more often *campesinos* cure themselves with the use of medicinal plants. Here I use the term ‘cure’ instead of heal, because the villagers consider that their medicinal plants actually *cure* their illnesses, as opposed to pharmaceuticals that do not. While this is not in accordance with Waldram’s (2000) definition, here I am concerned with presenting people’s narratives as they presented them to me. That is to say that I do not address medical efficacy in this thesis, as it is a formidable and arguably impossible task to discern the medical efficacy of ‘traditional medicines’ within a biomedical, scientific framework (Stoner 1989, Waldram 2000). Nevertheless, different people draw on the various techniques and medical ideologies at different times for different reasons. It follows that the choice of technique is also an expression of cultural values. As such, discourses surrounding their choices reveal social and cultural insights that can help practitioners and planners inform how PHC could be better delivered to serve the interests of those who benefit from it.

### 1.2.3 Biomedicine

A critical historical examination of the western modern medical system reveals that the term ‘biomedicine’<sup>5</sup> refers to the medical system that was professionalized by a group of wealthy, powerful practitioners in the mid 18th century through the creation of the American Medical Association (Baer *et al.* 1997, Jones & Moon 1987). Due to “financial backing of initially corporate-sponsored foundations, and later the federal government for its research activities and educational institutions, biomedicine asserted scientific superiority and clearly established hegemony over alternative medical systems” (Baer 2003, 46). As such, it is a politically and economically influenced construct. This quelled other competing models such as chiropractics and homeopathy. The term biomedicine suggests a “sense of scientific ‘objectivity’, which is inappropriate” (Janes 1999, 1803). Although biomedicine claimed to assert scientific rigour, after professionalizing only those schools deemed scientific by the American Medical Association were legally allowed to teach medicine (Baer *et al.* 1997). At the same time, those schools that allowed women, black people and other ‘undesirables’ were deemed unscientific (Baer *et al.* 1997). These points suggest the constructed and hegemonic nature of biomedicine.

### 1.2.4 Traditional or indigenous medicine

As for ‘traditional/indigenous medicine’ there is an inherent risk in the attempt to define such a heterogeneous set of practices. However, a general description is useful in this context. To begin, it is important to recognize that the term ‘traditional medicine’ is constructed by discourses in health development (Pigg 1995). In that framework, the concept of traditional reifies the difference between traditional and modern. Thus to use the

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<sup>5</sup> Biomedicine is also referred to as western medicine, or modern medicine and these terms will be used interchangeably.



term 'traditional' in contrast to modern implies a stagnant system, long standing beliefs and static notions of cultural authenticity (Janes 1999, Pigg 1995), none of which are appropriate. Furthermore, the terms traditional or indigenous implies that what it is describing is unaltered by that which is *non-indigenous* (Janes 1999), however, in reality the majority of medical systems are culturally syncretic and borrow practices and techniques from other systems both traditional and modern (Barrett 1995; Casteñeda *et al.* 2003). Traditional medical systems are usually and broadly described as any of a variety of longstanding, culturally produced health care practices that do not adhere to the application of scientific medicine or biomedicine (Good *et al.* 1979).

The WHO (2002) refers to traditional medicine as including any practice under the following category: *i)* herbalists, *ii)* traditional birth attendants (*parteras*) *iii)* mechanical technicians, such as bonesetters (*bueseros*) and chiropractics, *iv)* and faith healers. While many, especially in the west, have romanticized traditional medical practitioners, power relations are just as much present when people visit these practitioners as when they visit biomedical doctors. Indeed those members of societies that are recognized by the rest of the community as possessing knowledge on how to heal wield power over other members of the group. Furthermore this definition consists only of traditional practitioners recognized by external bodies such as the WHO, and does not include the myriad lay practices, often place-specific and orally passed down from generation to generation, conducted in homes by un-trained women and other family members. For the purposes of this thesis, I will refer to traditional medicine in general as practiced by lay people, as well as formalized traditional medicine that fits into the WHO paradigm as 'traditional medicine'. When referring to either lay knowledge or specific examples of traditional medicine or medical techniques I will

refer to it as ‘indigenous (medical) knowledge’, ‘indigenous medicine’, ‘local (indigenous) medical systems’ or ‘lay (local) knowledge’.

### 1.3 Theoretical context

Because biomedicine is commonly thought of as a global body of knowledge and practices, and indigenous medicine a local one, a consideration of scale is inherent in this discussion. However, I do not imply that biomedicine and indigenous medicine are bounded entities, and this thesis explores the processes that occur between biomedicine and indigenous medicine with an awareness of the dialectical nature of global forces and local discourses (Del Casino 2004, Madge 1998). Del Casino (2004) suggests that, “the meanings of health and health care are inextricably linked to the complex, contested nature of social relations as they flow in, and are reworked through particular places” (p. 60).

The quotation that introduced this chapter indicates the presence of power relations. A few years ago in Añawi people were ‘forced’ through policies to visit the clinic in spite of the pre-existing, long-standing medical tradition in the region, and subsequently the informant tells us that they are turning back to their medicinal plants regardless of the policies. Such processes involving the negotiation of health care seeking occur within the politics of unequal power relations and economic disparities (Madge 1998). Thus, through an analysis of the spaces, relations, and discourses that occur between PHC and ‘traditional medicine’, an understanding of how global power relations can influence local level practices can be sought (Del Casino 2004).

Consequently, this thesis explores local knowledge as practised in the family at the household level or in informal social networks as distinct from more formal versions of ‘traditional medicine’ such as shamanism, or the practices of *curanderos*, *hueseros*, or *herbolarios*

recognized by external bodies such as the World Health Organization. Both expert and lay systems of traditional health knowledge can be theoretically distinguished from western medicine (Waldram 2000) although they may have incorporated certain practices from western medicine. With a few important exceptions (see work done by R. Finerman, Popay J. & Williams G. and C. Wayland) there is a dearth of research on lay medical knowledge, as opposed to more formal expressions of traditional medicines. There is also a lack of research on the relationship between biomedicine and lay knowledge. Most importantly, approximately 80% of people in developing countries rely on traditional medicine (WHO 2003) and a great deal of this is lay medical knowledge. Therefore, it is important to examine how local scale traditional medicine is affected when biomedicine, which is also an expression of a set of cultural values, is parachuted in. Furthermore, when there is a professional healer in the relationship, whether s/he is a traditional medical practitioner or a biomedical doctor, who potentially possesses deeper knowledge, and upon whose judgement the diagnosis depends, there are inevitably power relations. This thesis looks at lay people's power both to seek health care and to heal themselves.

When one is ill, it is typically through some medical system that help is sought. Because our very existence depends on our health, since time immemorial human societies have accumulated and organized knowledge to respond to the uncertainty of health. Medical knowledge has been organized into systems, which can be defined as "the knowledge and related practices [and social institutions] constructed by the healer, the ill, and their groups of relevant others through their interactions. Medicine is thus a "consensual knowledge that has legitimacy for both the providers and the users of medical attention" (Ayora-Diaz 1998, 189). Accordingly, medicinal and medical systems are "infused with enormous power" (Koss-Chioino 2003, 23). Medical systems are better understood as processes. As Stoner

(1986, 44) suggests, it is the *act* of utilization of various healing alternatives rather than the definition (complete with distinctions and boundaries) of health (medical) systems that is interesting. An understanding of medical systems as processes is more conducive to a critical analytical perspective, whereas looking at medical systems as static entities risks falling into a more descriptive perspective. It is important to realize that labels such as 'biomedicine' and 'traditional medicine' and their definitions can merely be tools around which concepts and arguments can be constructed. Too often these terms are understood to be bounded entities with the result of attributing agency to these systems, rather than to the people who create and use them. Such understandings are limited as they fail to recognize the dynamic qualities of systems and that entities are reshaped through ongoing processes.

In the chapters that follow, this thesis explores issues surrounding processes that occur at the interstices between biomedicine and indigenous medicine. Chapter two contextualizes PHC and indigenous medicine through a review of the literature. While this review is not exhaustive, I seek to highlight themes that are relevant to and lead up to my research questions. Chapter three outlines the geographical setting of the village where the research was conducted, and describes the methods I use to conduct the research. Chapters four and five speak to my research questions and draw specifically on my research. Chapter four describes Perú's PHC system, and answers my first research questions by drawing on interviews with health workers and villagers. Chapter five focuses on the local use of indigenous medicine and draws on interviews primarily with the villagers. Chapter six concludes the thesis, offers policy suggestions and proposes further research.

## Chapter 2: Primary Health Care and indigenous medicine

### 2.1 Background

The tensions and debates between the ideologies of PHC and indigenous medicine have their history in international health initiatives. These initiatives originated from a framework of modernization and intervention with the inception of the World Health Organization in 1948 (WHO 1958). Primary Health Care (PHC) responded in the late 1970s to the shortcomings of these initiatives and focused on low-cost equitable health care for the poor, with more attention to prevention and quality of life issues than intervention (WHO 2003). PHC was not without its critics, however, and a debate was sparked between the original *comprehensive* approach to PHC and *selective* PHC, which claimed the comprehensive approach was too idealistic and costly to implement (Cueto 2004). PHC was proposed as essential, accessible to all, cost effective health care (Health Link Worldwide 2004). Nevertheless, governments found it difficult to implement PHC strategies because of rising inflation and subsequent economic restructuring. The health care reforms of the 1980s were undertaken in the context of neoliberal policies and enforced cutbacks in social spending, and took on characteristics of selective PHC.

Many countries in Latin America adopted such reforms to varying degrees. As part of health care cuts in Perú, however, the CLAS (*Comités Locales de Administración de Salud*)<sup>6</sup> system was established as a pilot project in 1994. In spite of the fact that it was established

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<sup>6</sup> Local Health Administration Committees.

to respond to cuts in health care funding, the CLAS program seems to follow the mandate set out by comprehensive PHC. While the rural poor in Perú have access to such clinics, they largely rely on lay knowledge of medicinal plants. Andeans also have access to a variety of *curanderos* (traditional healers), *parteras*, and *bueseros*. However, the people I interviewed did not seem to access such practitioners nor did they grant them much importance when I asked about them. Rather, many of the people in the village were involved with a research institute (IEPLAM – *Instituto de Ecología y Plantas Medicinales*) that assists them with the dissemination of information about and production of medicinal plants. This discussion provides the context for the following research questions.

### 2.1.1 Research questions:

- Considering that the CLAS was initiated under neoliberal reform, how well is it able to fulfill its original intentions of
  1. Reducing poverty by offering low cost health care
  2. Providing meaningful community participation
  3. Decentralizing administration as well as
  4. Fostering cultural sensitivity.
- How is the CLAS experienced by Añawayans who live in one of many rural communities whom the CLAS serves, and how can Añawayan discourses surrounding the CLAS inform us about how to serve them better?
- How is the role of the CLAS system negotiated at the household level on the healthscape of Añawayans?
- How have health care reform and the presence of the CLAS influenced the use of and the knowledge of medicinal plants?

- What information do discourses surrounding the use of medicinal plants (and / or medical ideology) reveal in terms of Añawayans' social relations? How can this information be incorporated into the planning and implementation of PHC in regions where long-standing medical traditions exist?

This chapter presents the policy context of this thesis and provides a framework in which to answer these questions. I review international health initiatives, the policies and debates in PHC literature, and Perú's health sector reform. I then contextualize local and indigenous medical systems by considering the policies promoting their integration in to PHC and the effects this has had on indigenous medical systems. This discussion provides context for local health care decision-making.

## 2.2 International health initiatives

In 1948 there was a formalization of international health care initiatives in developing countries (WHO 1958). This occurrence can be understood within the framework of modernisation theory. Modernisation espoused ideas of unilinear evolution of societies, in which lesser-developed countries had only to follow the examples of developed countries to reap the same benefits, and to enjoy the same qualities of life (Brohman 1996). One way this goal could be accomplished was through the dissemination of technologies. The health sector took up this cause with the discoveries of penicillin and DDT, which revolutionized the nature of health care (WHO 1958) through interventionist techniques of disease control. The WHO used such technologies and claimed to successfully eradicate specific diseases such as smallpox, yaws and malaria (Magnussen *et al.* 2004), which led to a sense of victory that extolled the curative nature of western medicine (WHO 1958). International bodies encouraged the governments of less wealthy nations to take on the

responsibilities of health care by building national medical systems. Health care thus became centralised in many countries, while traditional medical practices were deemed ‘backwards’ and barriers to the modernization process (WHO 2003). In the 1960s, international health initiatives continued to follow a modernist framework, and as a result of many successes, a high sense of confidence reigned, as is demonstrated in the following quotation:

The scientific discoveries and practical achievements of the past decade have stirred the imagination and roused our expectations for the future. *They have also served to confirm that health is purchasable.* This truth, increasingly accepted by modern societies, is well on its way to realization...[P]eople are beginning to ask for health and to regard it as a right (WHO 1968, ix, emphasis added).

Such a perspective may be interpreted as reductionist or interventionist, and suggests that ill health can be looked after merely with purchasing power. While it may be implicitly understood that the right to health also includes the right to live in conditions that are conducive to good health, the focus here is on scientific discoveries and that idea that health is purchasable.

Furthermore, we now know that an increase in the presence of western medicine and its technology does not necessarily correlate to improved health and higher life expectancy (Cueto 2004, Pedersen & Coloma 1983, & Wayland 2001). However, this is not necessarily a reflection of its efficacy, but may be for geographical or social reasons such as access to health care. For example, Miles and Leatherman (2003) point out up that to the present time there has been little improvement in health in the Andes, primarily due to “structural violence of poverty, political unrest, and the social inequality [that] have been dramatically played out in epidemics of cholera and dengue fever...ever-increasing rates of HIV-AIDS and the development of multidrug-resistant strains of TB” (p. 4). In the 1960s and 1970s, many researchers and health care practitioners realized this through first hand experiences in the field, which encouraged them to shift their priorities from cure to prevention (See



Behrhorst 1975 for example). This priority shift led to the Alma Ata declaration in 1978, which first introduced Primary Health Care as an international initiative.

### 2.2.1 Primary health care

Fuelled by disillusion with modernization and interventionist<sup>7</sup> frameworks, the idea of PHC was first declared at the World Health Organization's (WHO) Alma Ata conference in 1978 as part of a strategy to achieve the goal announced by the WHO and the United Nations Children's Fund (UNICEF) of "health for all by the year 2000." This goal reaffirmed the WHO's definition of health as not only the absence of disease, but a state of "complete physical, mental and social well being" (WHO 1946, cited in Magnussen *et al.* 2004) and intended to ameliorate health care in developing countries with this definition in mind (Magnussen *et al.* 2004). The Alma Ata declaration was the manifestation of a shift in priorities of international health initiatives. It was recognized that efficient and effective health care and pharmaceuticals were beyond the financial possibilities of many people in developing countries, and what was needed was low cost, efficient care that covered the entire population (Cueto 2004). It responded to critiques of centralized top-down programs fixed on particular diseases such as malaria, and focused rather on the idea that the main causes for illness and disease were social and economic (Cueto 2004, Health Link World Wide 2004). The declaration was directed to all governments in the world to encourage their efforts to improve the health of their populations (WHO 2003). Developing countries especially were encouraged to adopt PHC as a means to ensure low cost, quality health care for their populations.

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<sup>7</sup> By interventionist, I refer to methods that intervene rather than prevent. For example, rather than attempting to avoid disease in the first place, the focus was placed on how to cure the disease once it had manifested. Another example is that rather than avoiding malaria by living where there are no mosquitoes, DDT was used to control mosquitoes.

The term *Primary Health Care* was first used in the 1960s by the Christian Medical Commission, an organization of the World Council of Churches in Geneva, and the Lutheran World Federation, which trained village workers in developing countries and focused on grassroots level strategies (Cueto 2004). This idea was influenced by the seeming success of the 'barefoot doctors' in China (Crandon 1983) who were a diverse group of peasant/farm-workers that had previous knowledge of traditional medicine and medicinal herbs, and who were briefly trained in biomedicine (Hillier 1987). However, there was an important difference between PHC and the barefoot doctor program of China. Whereas the barefoot doctors were rural, coming from the same cultural context as the people they treated, the PHC model assumed biomedicine as its point of departure. Even if PHC doctors and health care workers came from the areas where they treated, they were trained primarily in biomedicine, which differs radically in ideology from the local populations they set out to help.

Contrary to the previous belief that traditional medical systems would quietly disappear from the healthscape, at the time of the Alma Ata declaration people continued to rely on traditional medical systems, and in fact they were actually thriving. With this in mind, the PHC strategy would integrate traditional medicine and be executed with an attitude of cultural sensitivity. Also, rather than focusing merely on technology and disease intervention, more attention was given to preventative measures and *improving* health. To achieve this, it was believed that broader factors that influence health such as sanitation and clean water were just as or more important than merely providing health services (WHO 1978).

The three pillars of PHC, community participation, rural health infrastructure, and intersectoral cooperation (Altobelli 2002), create the backdrop for the principal intentions

laid out by policy makers in Alma Ata. These intentions included: *i)* to provide low cost health care, *ii)* to promote self-reliance via community participation, *iii)* to extend health care service to remote rural regions rather than build on urban hospital infrastructure, as well as *iv)* to foster an 'intersectoral' approach in which various organizations, including those outside the realms of biomedical hospital care, work on issues related to health (Cueto 2004). Under this intersectoral approach traditional medicine and traditional practitioners were to be afforded more space and respect within the PHC model (WHO 2003).

In order to achieve these intentions, three key criteria were included in the Alma Ata declaration (Cueto 2004). First, it was important for countries to adopt suitable technology that reflected the socio-economic status of the adopting country. Since the governments were expected to fund the PHC systems, they were meant to be cost effective and culturally sensitive. As such, a preference for the construction of rural health posts, rather than more urban hospitals, was highlighted. Secondly, PHC was to run against the grain of medical elitism, and to foster the training of lay personal as well as to encourage community participation. This attitude also reflected a desire to work more closely with traditional practitioners. Thirdly, the Alma Ata declaration stressed that people's good health was the cornerstone of socio-economic development. Health was conceived of as part of the process of development rather than a short-term intervention (Cueto 2004). This set of principles suggests that health is more than just the absence of disease, but is influenced by a broad set of social factors such as poverty, education and social unrest and instability (Magnussen *et al* 2004).

### 2.2.2 Selective versus comprehensive PHC

Shortly after the PHC declaration was made, the goal of PHC providing low cost universal health care for the poor and rural was deemed infeasible, because its “scope and resource constraints made it unattainable” (Magnussen *et al.* 2004, 169). This provoked the debate between *selective* and *comprehensive* PHC, which reflects the “tensions between social and economic approaches to population health and technology or disease-focused approaches” (Brown *et al.* 2006). The 1979 *Health and Population Development Conference* was centred on a paper entitled “*Selective Primary Health Care: an Interim Strategy for Disease Control in Developing Countries*”<sup>8</sup> in which selective PHC was offered as an interim strategy until comprehensive health care could be achieved. Indeed, many governments were finding it difficult to implement comprehensive PHC strategies because of rising inflation and subsequent economic restructuring (Cueto 2004). Another difficulty in implementing comprehensive PHC was that many medically trained doctors were unwilling to move to remote rural areas, and give up urban wages and opportunities.

On the other hand, it was suggested that the best way to ensure good health would be through a selective approach, by addressing the most significant specific causes of death in each region that could be controlled by immunization (Magnussen *et al.* 2004). As such, governments and international organizations such as UNICEF and the World Bank adopted vertical programs<sup>9</sup> characteristic of the selective PHC. Since these interventions were easy to monitor and evaluate, various countries as well as international health organizations favoured this strategy (Cueto 2004). However, this selective approach is grounded on a “reductionist definition of health” (Janes 1999, 1808), and as a result, many of Alma Ata’s other more

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<sup>8</sup> Walsh J, and K.S. Warren. (1979). *New England Journal of Medicine*, 301(18), 967 – 974.

<sup>9</sup> The main four programs were growth monitoring, oral rehydration therapy, breastfeeding and immunization, (GOBI), and later, family planning, female education and food supplementation (FFF) were added (Magnussen *et al.* 2004, Janes 1999, Cueto 2004).

wide-ranging ideals addressing social equity, poverty, prevention promotion, and community participation were cast aside to focus on efficiency as the most important objective (Cueto 2004, Magnussen *et al.* 2004).

On the other side of the debate, those who support the idea of comprehensive PHC argue that selective PHC resembles the top-down initiatives, originally criticized in the 1978 declaration for not addressing local needs or cultural, and that it fails to address social and socio economic causes of disease (Cueto 2004) as well as quality of life issues. In fact, some argue that comprehensive PHC was never attempted, seeing as the shift towards selective PHC happened so quickly after Alma Ata (Magnussen *et al.* 2004). Furthermore they claim that the use of interventions such as oral rehydration therapy covers up problems of sanitation that need to be addressed (Cueto 2004). However, early on in the debate, Taylor and Jolly (1988) claimed that such a debate is essentially a straw man because *selective* care is a component of the Alma Ata document, and that those who critique comprehensive PHC fail to recognize this, claiming that PHC in its original form was idealistic and infeasible. It follows that the Alma Ata declaration means different things to different people. Regardless, the delegates of the Alma Ata conference declared that at the very least, countries should adopt a variety of strategies that work in unison, combining both selective PHC and comprehensive PHC, given that there is no indication in the Alma Ata declaration that either strategy could stand on its own (Taylor & Jolly 1988).

Nevertheless, in the 1980s and 1990s many international health organizations such as WHO and UNICEF favoured selective PHC and thus did not adequately fund comprehensive PHC establishments (Cueto 2004). As such, health care decision-making was distributed to “foreign consultants with technical expertise” (Hall & Taylor 2003, 178) in the aforementioned vertical programs, and most agencies were reduced to offering a single

intervention, or treatment for only one disease (Cueto 2004). In the 1990s the World Bank demanded health sector reform as a condition of lending to developing countries.

Additionally, the World Bank “considers the delivery of health care services in terms of the economic benefit that improved health could deliver, and sees health improvement mainly in terms of improvement of human capital for development rather than as a consequence and fruit of development” (Hall & Taylor 2003, 19). This shift clearly diverges from the original comprehensive tenets of the 1978 declaration.

### **2.2.3 Health sector reform**

During the 1980s and 1990s, while health systems continued to be reproached by the international community and health disparities grew, governments in Latin America also adopted selective PHC strategies as part of their health sector reform. Selective strategies, because they focus on a specific disease and not broader influences on health, are more cost effective and thus more appropriate in times of health care cutbacks. Thus, health care initiatives took on a distinct neoliberal flavour as social spending was reduced and health budgets were cut.

The international institutions that imposed restructuring believed that health sector reform was needed to respond to poorly funded and inadequately planned health services that were distributed unequally throughout Latin American countries and did not respond to the needs of the population (Puig-Junoy *et al.* 2002 *and references therein*). Others argued that the high rates of preventable illness that continued to run rampant in Latin America, belied the funds that were actually spent on health care, as well as the perceived advances made in the region (Homedes & Ugalde 2005), emphasizing the need to reform. Thus, health sector reform was meant to expand health care coverage and access, as well as improve the health

of the public. Consequently, the reforms aimed to improve the quality of health services, and by extension, enhance efficiency in health care delivery by controlling the funds spent on health care by governments, donor agencies and NGOs (Langer *et al.* 2000). To meet these goals, the international financial institutions encouraged governments to include the private sector in the delivery of health services, cut publicly funded services, include the participation of the community, and provide a basic package of services to attend to the most poor, as well as to decentralize administrative duties (Armada *et al.* 2001, Homedes & Ugalde 2005, Puig-Junoy *et al.* 2002). Neoliberal critique asserted that governments were inept at managing social spending and thus supported the commodification of health care services by encouraging governments to give over control to the private sector (Armada *et al.* 2001, Homedes & Ugalde 2005). Decentralization was promoted in order to shift fiscal and administrative burden onto the provinces while 'liberating' states to pay external debts (Homedes & Ugalde 2005, Langer 2000).

The health sector reforms in Latin America have been, for the most part, unsuccessful and have led to less efficiency, increased inequity and high dissatisfaction among users without improving the quality of care they are receiving (Armada *et al.* 2001, Langer *et al.* 2000). Chile was the first country to reform its health care system under the Pinochet government in the early 1980s (Puig-Janoy 2002) and most other countries went through varying degrees of the neoliberal health reform throughout the 1980s and 1990s. Many countries had difficulties implementing these reforms, and many have merely implemented them in a piecemeal fashion (Homedes & Ugalde 2005, Langer 2000).

Perú on the other hand, despite economic reform, appears to be delivering basic health services that have some elements of comprehensive PHC. In 1994 the Ministry of Health in Perú implemented the CLAS program to address the health needs of the lowest

income people in the country that live in rural and marginal urban zones. Since its inception as a pilot project in 1994, it has enjoyed enormous success simply in the sheer number of clinics that have become CLAS clinics<sup>10</sup>. The CLAS system is part of a strategy to reduce poverty, by offering low cost health services and exonerating the poorest of the poor their fees for service. The CLAS also has community members on the advisory board of the clinic democratically elected by the community they serve. The CLAS embraces a policy of administrative decentralization in order to bestow power at the local level, and in an attempt to bridge the cultural differences that can make it uncomfortable for low-income and indigenous people to visit the clinics. Their mandate explicitly aims for cultural sensitivity. CLAS clinics are now a very significant player on the healthscape of rural and low income Peruvians and accordingly, the local CLAS clinic plays a role in the lives of the Andean villagers with whom I researched. It is surprising that being initiated under neoliberal reforms the CLAS attempts to address issues such as low-income health care, political decentralization, community participation and other approaches that have a distinctive comprehensive PHC flavour.

## **2.3 Local health care decision making in Perú**

### **2.3.1 Effects of biomedical dominance on indigenous medical systems and knowledge**

Health sector reform occurred in the context of global change, transculturation and the disillusion of modernity. Previous to cutbacks in social programs, people were sometimes forced into using primary care clinics, even though they relied on long standing

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<sup>10</sup> The doctors along with the community must apply to the government to become a CLAS clinic. Information pamphlets have been made by the government to inform communities of the steps that must be taken to partake in the CLAS clinic. Such details will be addressed in more detail in chapter 4.



traditional medical systems long before they were ever introduced to biomedicine. With the professionalisation of western medicine, alternative forms of therapy have been disregarded, appropriated, seen to be inferior, or referred to as either fraudulent or primitive (Farnsworth *et al.* 1985, Pedersen & Barufatti 1985, Wayland 2001). Also it has been reported that health workers undermine traditional medical knowledge (Wayland 2001), which inevitably affects health care decision-making. Examples in the literature support this claim. For instance, Wayland (2003) interviewed a physician who scorned her patients for listening to their mothers and friends about the use of medicinal plants. She asked her patient how long her mother or friends had gone to school, saying that they should listen to her because she was a trained and educated medical doctor. Wayland (2003) suggests that by controlling knowledge, physicians protect their authority. The physicians in her research felt that it was up to them to educate their patients about the medicinal plants even though they claimed not to be knowledgeable about them.

Other ways in which biomedical health care workers in developing countries attempt to exert control over the use of indigenous medicine are by claiming that their treatments are ineffective, by denying that they are used (e.g. because the knowledge has been lost) or by underestimating their use (Wayland 2003, 2004). Wayland (2004) also observed that some physicians claimed that people misuse medicinal plants, and harm themselves, though rarely are they able to provide an example of that happening. As a result, many indigenous people formed dependencies on biomedical clinics, and some began to forget the ways of traditional medicine.

On the other hand, the poor exert control in their own way. For example, Browner (1989) recounts that because the government ran the clinic, indigenous women in rural Mexico saw the local medical clinic as a form of state penetration and discontinued using it.

In Wayland's (2003) research in Brazil, the poor turned back to herbal medicines, claiming their plants and their traditional ways cured better than pharmaceuticals as a way to reclaim control over their own health care. As such, in spite of the loss of knowledge and the large role of biomedicine, alternative medical techniques have continuously occupied an important place on the healthscape (for example, see Madge's 1998 article on local medicine in Gambia). Consequently their use has never allowed biomedicine to occupy a dominant role (Baer 2003). These examples corroborate Del Casino's (2004) idea that the "contested meaning of health(care) is inextricably tied into the systems of power and authority that mediate everyday life" (p. 71) and is central to understanding these discourses. Indeed other authors suggest that health care choices and the discourses surrounding them are not only about seeking health care, but also about cultural identity, and reflect information about "how the social world is constructed" (Miles 2003, 110).

### **2.3.2 Local use of indigenous medicine**

Indeed currently in the 'everyday' lives of most of the developing world, far away from the debates of PHC, people access medicinal plants, indigenous medicine and local knowledge before health clinics at the onset of ill health (Browner 1989, Wayland 2001). Especially in rural areas, people turn to modern medicine as a last option, because of geographic accessibility and expense (Wayland 2004). Many report that the return to the use of traditional medicine is because biomedicine has become out of the reach of many of the poor due rising costs of health care after the reforms. However, even with the easy access to both professional health care workers and traditional healers, women are often found to be the first caregivers (Browner 1989). Likewise, in Añawí, while many of the more formal traditional medical practitioners appear to occupy less and less of a role in people's health

care choices despite the return to traditional medicines, medicinal plants feature dominantly on Añawi's healthscape. As such, I will discuss their use of indigenous medicine primarily from the perspective of the local use of medicinal plants.

The use of and knowledge of medicinal plants is an interesting point of departure for this discussion, as they offer place-specific examples of local medicine. Although medicinal plants have received widespread attention in a variety of disciplines such as medical anthropology, ethnopharmacology and ethnobotany, a great deal of this literature focuses on the biological and pharmacological action of plants (Madge 1998) while paying little attention to the social context of the use of plants (Wayland 2001). An examination of the cultural and social aspects of medicinal plants is important in that it can offer insight into discourses surrounding health care choices when various options are available.

The *local* use of indigenous medicine is often overlooked. It is perhaps a vestige of biomedicine, where knowledge is controlled by a select few who have "expropriated health from the public" (Illich cited in Cueto 2004, 1865), that it is often assumed that traditional medical practitioners possess more refined knowledge of traditional medicine than laypersons. While this may be true in many cases, (see Vandebroek 2004 for example) Browner (1989) found in Latin America that most illnesses were treated in the home rather than with *curanderos*, as is often believed. At the time of Browner's (1989) study, there was a growing realization that women possessed specialized knowledge about the health of their family members: "*curanderos* don't know much, we know more about healing" (Browner 1989, 165). This supports the argument made earlier that in many families, the home is the first site of health care.

The knowledge of medicinal plant use is very complex and not homogenous in all regions. The proponents of biomedicine tend to understand 'traditional medicine' in a static

and essentialist manner, and it is important to note that indigenous medical systems are accurately described as processes, and embodied through social relations and practice. Because they are often passed down orally, they vary according to place and even to families within a specific place. Indigenous medical systems have value and meaning beyond their material aspects (Crandon 1983), and Janes (1999) argues that the significance of indigenous medical systems is most likely due to “their ability to produce for lay people diagnostic discourses that reference centrally important cultural principles and to follow these with concordant treatments” (p. 1807). Because “medical decisions are life decisions and bear upon all aspects of human existence” (Stoner 1986, 46) illness and health cannot be detached from other social contexts and it is thus important that indigenous medical systems be considered within their own conceptual framework (as opposed to a scientific framework) for them to be appropriate and meaningful. The complex nature of medicinal plant knowledge is documented in the literature. For example Browner (1989) observed in Latin America that younger women were just as likely as older women to know about medicinal plants and that there is little differentiation in knowledge among “age, gender, class, educational attainment, religious beliefs, and income” (Izugbara *et al.* 2005, 1). Madge (1998) documented a reverse situation in Gambia where older women possessed the most knowledge about medicinal plants, most likely because they were responsible for the well being of their extended families.

Social networks can be the main conduits for information concerning health and can offer people a matrix of knowledge and advice (Izugbara *et al.* 2005). Medicinal plants in many cases are grown or harvested and shared freely among friends and families in time of need (Wayland 2003, 488), and the choice of which plant to use or where to seek health care often comes from recommendations from “lay referral networks” (Pedersen & Baruffati

1985, 1145, Izugbara *et al.* 2005). This suggests a recursive relationship between knowledge production and use, and between social networks and health seeking behaviour (Izugbara *et al.* 2005).

People access medicinal plants before health clinics for a variety of reasons. From a selection of studies (Izugbara *et al.* 2005, Pedersen & Baruffati 1985, Wayland 2001, 2004), six main reasons for using medicinal plants were culled: they are described as stronger and more effective than pharmaceuticals; they are geographically accessible and affordable; medicinal plants are traditional and natural; those that use medicinal plants do not need to consult the doctor and thus feel more independent; medicinal plants are culturally appropriate and hence people know more about them than pharmaceuticals; and finally because those that use them believe plants to be more appropriate for certain illnesses, such as those that do not typically have a cure and must be endured, but where symptoms can be relieved such as colds, flues and chronic illnesses.

Drawing on these ideas, it has been suggested that medicines can embody certain cultural and social values and can be a significant source of commentary on competing social values and worldviews (Crandon-Malamud 1991, Wayland 2004). Indeed, consideration of the local use of indigenous medicine and medicinal plants can offer cultural information that is useful in understanding how people negotiate their choices between long standing medical systems and biomedicine. Just as biomedicine reflects an “ethnomedical representation of western systems of knowledge” (Miles & Leatherman 2003, 9) so too is indigenous medicine a reflection of people’s environments as well as social, cultural, political, and economic relations and structures. To elucidate, the Amazonian people in Wayland’s (2004) study made a rapid shift to modernity, by moving from the Amazon to urban centres only to find that it did not benefit them. Since pharmaceuticals represent a manifestation of modernity

to them, many said they prefer to use medicinal plants. The use of these plants provides people with a link to their culture, as the knowledge had been passed down orally for generations, and the stated preference of medicinal plants over pharmaceuticals was one means to reject that which was 'modern'. However, because of poverty this is not always a choice, hence, when pharmaceuticals are available but beyond their financial means, people prefer to undermine their value, or deny their desire for them rather than admit they cannot purchase them (Bastien 2003), and instead turn to medicinal plants.

The observation that medicinal plants are sometimes used to reassert people's cultural identity and defy 'that' which is modern (indicating *conflictual* medical pluralism) (Pederson & Baruffati 1985) builds on these ideas. For example, when people do use pharmaceuticals, they disparage them at the same time. This suggests a disconnection between discourse and practice, and "can offer counter-hegemonic critique of some aspects of Amazonian modernization, urbanization and development" (Wayland 2004, 2415). In other cases, pharmaceuticals have been rejected because of negative experiences (Pedersen & Baruffati 1985) or because of deleterious side effects (Wayland 2004). On the other hand, many described pharmaceuticals as 'weak' or 'diluted' as opposed to medicinal plants (Wayland 2004). However, at the same time, Wayland (2004) found that while her respondents access medicinal plants for the majority of cases, they continue to access health clinics and use pharmaceuticals all the while denigrating them.

Añawayans claimed unflinchingly that they prefer to treat themselves with their home remedies of medicinal plants than go to the clinic. They repeatedly told me that medicinal plants cure disease, whereas pharmaceuticals merely calmed their illness. The enthusiasm for medicinal plant use increased with their involvement with IEPLAM and the formation of a medical plant committee. On the other hand, there was a great deal of variation in people's

reliance on the clinic. Some people visited the clinic when they could afford to, some had only been to the clinic a couple of times in their lives and many others had never been to the clinic at all.

## **2.4 Conclusions**

This chapter contextualizes my research questions by considering the interstices between PHC and the local use of indigenous medical systems. I examine the history of Primary Health Care as a manifestation of international health initiatives and introduce the debates between comprehensive versus selective PHC. While the comprehensive approach is broad in scope, the selective PHC strategies that many developing countries have adopted under the guise of neoliberal health reforms trump efficiency over social objectives for improving health systems. Peru's CLAS system occurs within the context of neoliberal health reform and economic restructuring, however, it appears to have adopted comprehensive goals. Far away from this debate, though, people in developing countries continue to rely on local indigenous medicine. However, the presence of biomedicine has influenced indigenous medical systems in a variety of ways. I discuss this influence in a number of studies, as well as the use of indigenous medicines, and the social relations that occur during its use are considered.

## Chapter 3: Geographical Setting and Methods

### 3.1 The Geography of Añawi

Añawi lies approximately 50 km from Cusco in the Sacred Valley of the Inka region of Perú (see Figure 3.2, Figure 3.2, and Figure 3.3). Añawi is composed of three informal zones determined by elevation – lower Añawi (3300 m), middle Añawi (3400m) and upper Añawi (3500m). A paved road runs from Paukcha to Chunyo, the neighbouring village, from which a dirt road, in poor condition, leads to and then winds through Añawi, stopping in middle Añawi. Also, a walking trail starts from lower Añawi, cutting through the switchbacks of the dirt road, and some of the villager's adobe houses run along the length of the trail. Each family's dwelling consists of two or three small adobe houses, as the living area is often separate from the cookhouse. The cookhouse is usually a small adobe dwelling, with a mud stove in one corner. Most families raise guinea pigs for family consumption or to sell, which also live in the kitchen, often in the opposite corner of the mud stove and within easy reach of the cook.

In their fields they grow potatoes, corn, broad beans, onions, wheat and turnips. They also raise cows, guinea pigs, donkeys, sheep and goats. While the Andean economy has been significantly monetized, most of the people in Añawi remain subsistence farmers. This relationship is a significant contributor of conflict concerning their local economy. They have no fixed income, and from the little money they make selling produce or animals, they are expected to pay for services such as education and health care.





*Author's photo*

*Figure 3.1: Añawi Village and surrounding area*



*Author's photo*

*Figure 3.2: Añawi Village*

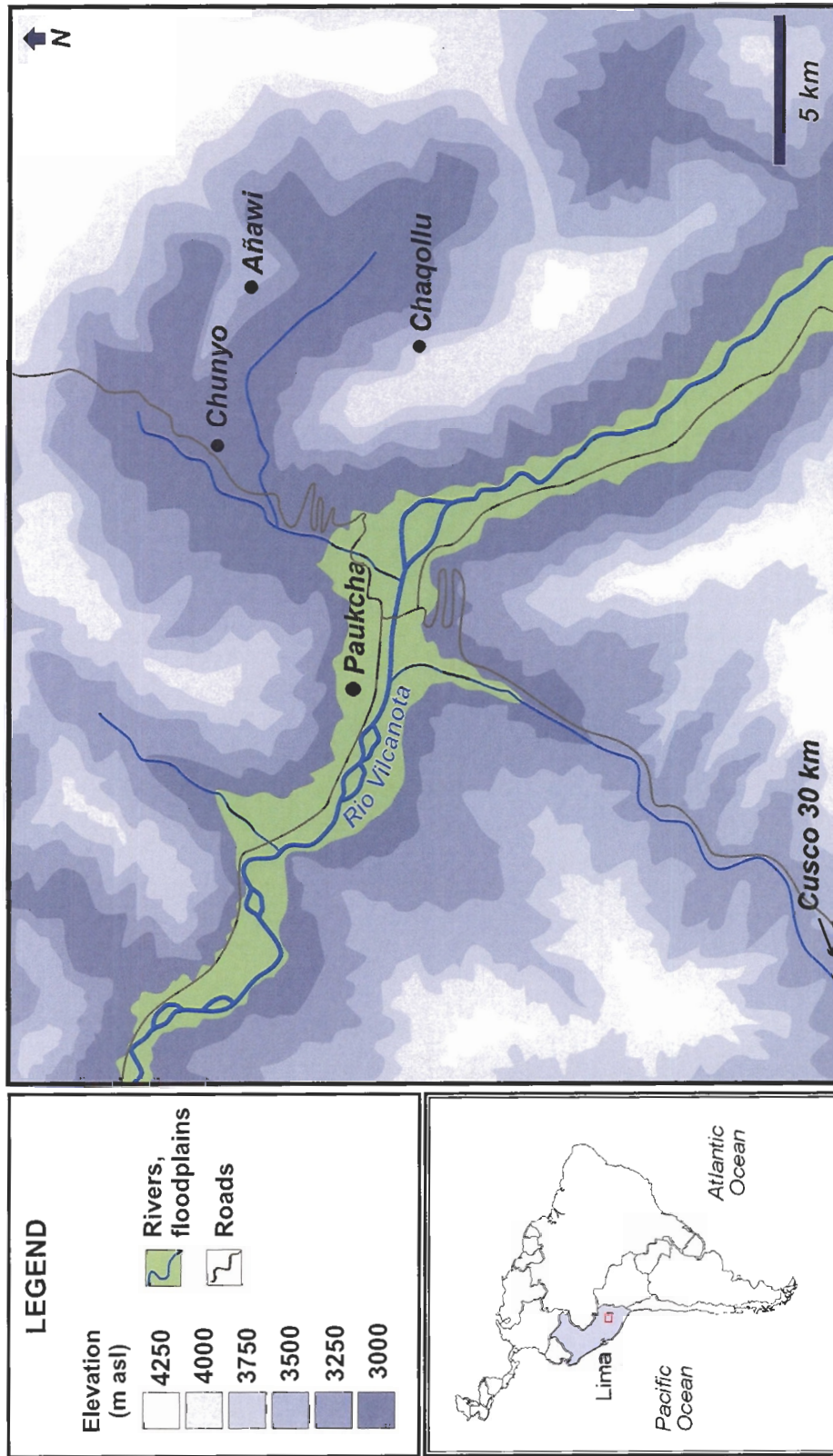


Figure 3.3: Location map of Añawi village and surrounding area. Main map area is highlighted on inset map of Central and South America (red rectangle). Main map adapted from: Mapsheet 2544 (27-s) J631 Edition 2, Instituto Geográfica Nacional de Perú.

Añawayans, for the most part, eat the plants and animals that they raise. They are proud of their food and consider it natural and healthy, and they attribute their good health to this. However, rice, pasta, and sugar in its many forms are desired and sought after foods. When they can afford it, they eat sugar in the morning with breakfast and rice and pasta for special occasions such as birthdays. Because they cost money, they are considered luxury items, and status and prestige accompany the consumption of such products. As the rural economy becomes more monetized Añawayans have more access to refined foods. It has been widely reported that the changing diets in developing countries and among indigenous populations have led to increased rates of diabetes and related dietary problems. While there is no evidence to suggest that Añawayans are starting to develop diseases such as diabetes, the change in diet has had some repercussions. For example, the local dentist informed me that there was a high incidence of cavities and tooth-loss due to increased intake of sugar and refined carbohydrates.

Some men in Añawi leave the community for extended periods of time to work in mines or road construction sites, often away from the village to work elsewhere, and thus have slightly more income. Although one could characterize all Añawayans as poor, there was in fact a great deal of variation in their incomes. The initial questions I asked my research participants revealed that their incomes ranged from nothing to 30 PEN<sup>11</sup> per week (up to \$12 Can). Some of the people lived only from what they farmed, while others had one family member that spend sometimes up to four months working in different regions in Perú. Añawayans were more likely to sell produce and livestock when unexpected expenses came up, such as when someone falls ill and must either be taken to clinic (or purchase pharmaceuticals). In essence their livestock acted as a fragile bank account.

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<sup>11</sup> Peruvian Nuevo Soles. 1 PEN = 0.34 CAD

Many of the people I interviewed demonstrate and sometimes stress that people in the village are very different from one another. Though it was not always the case, my research participants in lower Añawi tended to be more involved in the monetized economy, went to the clinic or pharmacy more in the case of illness and were more likely to sell their produce, while those in upper Añawi relied more on subsistence farming to meet their family's needs, were more likely to use medicinal plants in the case of illness, and less likely to sell their produce. Geography did play a role in this relationship, seeing as it is more difficult to get to the village, and hence the market, without a road.

Añawayans' native tongue is Quechua. Children, many of the men and those women who have attended school, also speak Spanish. However, most women are unable to speak Spanish or spoke broken Spanish. Many of the couples including those with children in Añawi live in common law arrangements because the marriage license is too expensive for them. For the families in which the father leaves the village to work, the consequences of this in terms of health care may be significant. Working outside the village can give men access to health insurance from the company he is working for. However, without a marriage license, neither his wife nor children have access to his health insurance. Future research needs to address this situation and determine the effects this may have on health outcomes, since children and women typically require more medical attention than men.

The people of Añawi have access to a CLAS clinic in Paukcha that charges a user fee for consultation, as well as a PHC clinic in the neighbouring village. While the PHC clinic is approximately three kilometres from lower Añawi, it is rarely open, and there are no doctors on duty. In the whole time I visited Añawi, I did not see the clinic open once, the building looked derelict and unused, and no one could tell me its hours of operation. While the

CLAS clinic in Paukcha is well equipped and appears to be successful<sup>12</sup>, it is difficult for the villagers to access the clinic. It is approximately 10 km from Añawi and would take several hours to walk there. Otherwise, a taxi could be called to middle Añawi (with the one telephone that exists in the village); adding considerable expense in addition to the user fees the clinic charges. Furthermore, the road to the highway is in very poor condition, which could lead to a great deal of discomfort if one was ill. The other option is to travel on foot to the highway and catch a *combi*<sup>13</sup>. For this reason, and many others, many of the people in Añawi care for their health at home, among family and friends.

### 3.2 Methods

In this section I consider the methods I used to conduct this research, and include some of the challenges I faced during my fieldwork. This research is situated within a health geographies framework, as described by Kearns and Moon (2002). I draw on critical cultural theories and ethnographic methods from critical medical anthropology. To that end, I employ a variety of ethnographic techniques, which responds to Moon's (1995) call for "...particular methods, notably interpretive approaches such as unstructured conversations, and participant observation." Specifically I used semi-structured interviews, participant observation and a number of document sources including health statistical data, pamphlets and other documents from the Ministry of Health of Perú, photographs, minutes from meetings held by IEPLAM, and field notes.

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<sup>12</sup> I draw this from the fact that in addition to the regular staff (doctors, nurses, and technicians) this CLAS clinic also has a specialist (a dentist) that they must hire from the revenue the clinic makes.

<sup>13</sup> A *combi* is a van that transports people from village to village. It is slightly larger than a North American seven passenger mini-van; however there appears to be no limit to the number of people that can be loaded into the vehicle. Also, they do not run on a schedule, which can lead to long waits.

### 3.2.1 Semi-structured interviews

From June 23 to September 24, 2004 I conducted a total of 53 interviews. These included one from a Ministry of Health official in charge of the PAAG<sup>14</sup> (*Programa de Administración de Acuerdos de Gestión*, or Administration Program for Management Agreement), seven with CLAS members<sup>15</sup>, two with IEPLAM administrators, 38 with residents of Añawi, as well as five additional interviews held with *curanderos*, herb vendors, and a couple of rural women from another community. The CLAS members were from two different clinics. I refer to the first clinic I visited as Clinic A, and the second as Clinic B. Añawayans have access to Clinic B. All interviews were held in either Spanish or Quechua. The interviews conducted in Quechua with the aide of a translator were translated into Spanish on site. After working with several people, I hired one person to be my guide and Quechua interpreter for the remainder of my research. Participants were asked to sign a consent form, and pseudonyms were assigned for each participant. Pseudonyms were also assigned for the towns and villages involved, unless I am referring to Lima or Cusco, for reasons of confidentiality.

I arrived in Perú with only one key informant, a journalist and researcher I had met on my previous trip three years earlier. My efforts to secure contacts before arriving in Perú were largely unfruitful, and I assumed that I would have more luck once I arrived. As it was, finding people to interview, and in particular a village that would allow me to research with them was very difficult. There were a number of reasons for this, of which I will describe only the most important. Being an inexperienced researcher and in a different country, I found both the interviews and recruiting participants a challenging endeavour. Although I

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<sup>14</sup> This is the program under which the CLAS systems falls.

<sup>15</sup> These included doctors, a dentist, medical technicians, and an elected community member. I also had one additional conversation and later email correspondence with a doctor that I met on a long bus ride who had previously worked with the CLAS program.

had travelled to Perú previously and had read about Peruvian culture, I was still naive about cultural norms and expectations. I therefore lacked confidence in regards to my boundaries as a white, middle class, female academic, travelling alone with no children and no husband. I also learned very intimately what this 'position' meant to people as I asked them for their time and their words, and will address this in the following paragraphs.

I was somewhat familiar with the area and on a past trip had visited several villages that were geographically accessible. There has already been a considerable amount of research conducted in the Andes that I could draw on, and I was advised I may have an easier time finding contacts through people that already worked in those areas. On the other hand, I learned later that there had been a number of researchers that had somehow disrespected people they had worked with<sup>16</sup>. These stories circulated in the villages, and many communities were mistrustful and reluctant to work with outsiders. For my research to happen, it was of course imperative to be introduced to a community by someone who already knew the people that lived there and was trusted by them.

Another difficulty was setting up meetings and appointments with people. In Perú, people are not ruled by the clock as we are in North America, and there are simply more variables that can impinge on people's time. People rarely assume that an appointment is set in stone. My attempts to obtain interviews and secure contacts were challenging and often farcical. For example, my first interview with the doctor that manages the CLAS programme at the Ministry level, took me three weeks of negotiating with the bureaucracy of the Ministry of Health, only to secure a brief 15-minute interview. This prepared me for the various other experiences I would have booking meetings and appointments. Appointments

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<sup>16</sup> For example, I was told of an anthropologist who had worked in a rural community on the subject of weaving. On her departure, she took with her many weavings from the community women who had made them, promising that she would sell them in her home country and send them back the profits. That was three years previous to my arrival, and the community had still not heard from her.

were often not kept, and I would frequently wait for an hour or more for someone, only to be told that perhaps I should come back another time. I experienced frustration and exasperation with these events; however, these comments are not meant to disparage, but rather to acknowledge the difficulties in researching in developing countries. Not only can bureaucracy interfere with time, but there are also geographical and infrastructural challenges in places such as the Andes.

First of all, it is important to note that my research would not have taken place were it not for my contact with IEPLAM. The founder of IEPLAM introduced me to the community, and while my research participants obviously did not trust me automatically, many felt compelled to talk to me because of their vested interest in IEPLAM. I feel there were others who spoke to me out of genuine curiosity or interest in the subject matter, but unfortunately there were also those who I believe felt obligated to speak to me. I sensed this through their reluctance to answer questions, extreme shyness, and one-word answers to questions. In such cases, I tried to be sensitive to their discomfort, and kept the interviews short.

The interview guides I used were open ended and allowed for a great deal of input from research participants. In the case of the CLAS workers, I followed my interview guide more carefully, as the questions I had for them were more specific. In Añawi, my questions were exploratory, leading to conversation, though I did use the questions to guide me. I was more interested that they inform me what was important to them, rather than imposing my previously held ideas. The interviews lasted from 15 minutes to 1.5 hours. In the case of my guide, the president of the medicinal plant committee, as well as the founder of IEPLAM, we had several conversations and informal interviews that lasted several hours. As I got to



know the *campesinos*<sup>17</sup> better, I found I changed the interview guide to make it more appropriate.

### 3.2.2 Participant observation

Compared to more formal settings, such as interviews, the un-staged settings of participant observation allow spontaneous and iterative interaction between members and groups of the community and the researcher (Kearns 2000). This interaction facilitates the development of rapport and trust between participants and the researcher. This increases chances of reliable responses (Punch 2001); a quality not afforded by more structured research. This quality allows for the flexibility to act on unexpected turns of events or to explore unheralded information that would not have been unearthed in more structured research (Cook 1997, Hine 2000, Hoggart et al. 2002, Ley 1988). The lack of structure also serves the purpose of providing insight into the 'everyday' as it occurs in natural settings, rather than formalised settings such as interviews (Kearns 2000). In fact objectivity and distance are not sought through participant observation, as propinquity is actively solicited through contact and interaction with the community in order to explore underlying social meanings (Laurier 2003). This exploration is contingent upon a "methodology of *engagement*, not *detachment*" (Ley 1988). Indeed the researcher attempts to uncover social meaning systems through intentional involvement with the community being studied and the exploration of human relationships (Kearns 2000). That said, participant observation was not always easy and frequently not possible for my research.

In the clinics, it was difficult to spend a long period of time as they were extremely busy and I risked 'being in the way'. I offered to help in small tasks wherever possible.

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However, much to my chagrin, in several cases my status as a white foreign academic led some doctors, particularly in Clinic B to prioritize my interview with them over patients that had been waiting in the waiting room for longer than I had been there. After hearing the many complaints from *campesinos* about waiting time, I did not wish to exacerbate this for the patients waiting there. I found myself somewhat conflicted between wanting to obtain an interview and spend time with doctors, nurses and medical technicians, and not wanting to impose my presence. I was able to spend two days in Clinic A, several hours each time observing the interactions between doctors, nurses and their patients.

In the village of Añawi I attended one Medicinal Plant Committee meeting, which my guide translated for me from Quechua to Spanish, and helped with the weekly work that was to be done at the building site, which included helping to build a latrine, as well as tending to the gardens, picking flowers to make salves and ointments. On a different occasion I assisted in making salves out of seasonal plants. I made my first trip to Añawi on September 4, 2004. The president of the Medicinal Plant Committee, Vicente, offered to host me for three consecutive days the following week, find me a guide to take me from household to household, and set up a place for me to sleep in the medicinal plant building. Because September is the season to plant corn, he warned me that people would be busy, and I would have to check with him which days I could come to the village after the three days. I spent the nights on sheepskins on the cement floor of the medicinal plants committee building, and decided after that to travel to Añawi from the village daily.

Vicente assigned me different guides for each day. My third guide was a young woman who worked with the medicinal plant committee. She was extremely knowledgeable about plants, and we worked well together. I hired her for the remainder of my time in Añawi. The days we worked together were spent visiting homes, interviewing, and walking

in the village while she showed me the vast number of plants they used for medicinal and other uses that seemed to grow in every nook and cranny. I helped her prepare meals and spent time with her and her family, telling stories and sharing meals.

### **3.2.3 Documents**

I obtained documents from the Ministry of Health in Cusco that had health statistics for the region of Cusco. The clinics also posted their statistics for the clinic itself on its walls. I took digital photos of these statistics with the permission of the head doctor. The Ministry of Health also had various posters and pamphlets that I used either in their original form, or took photographs of them. I also obtained minutes of the meetings of the Medicinal Plant Committee of Añawi with their permission. These were helpful to witness attendance records, and read about issues that had arisen since the establishment of the committee. I also obtained a number of books, reports and pamphlets from local book sellers, second hand book shops, as well as *San Bartolomé de las Casas*, a center for research of regional Andes studies, and publishing company.

### **3.2.4 Analysis of qualitative data**

Upon my return, I transcribed the interviews I conducted. I did not translate them into English, except in the cases where I quote people directly in this thesis. I drew on the second main strand of discourse analysis as described by Lees (2004). I approached my interviews with the idea that “discourses are not simply reflections or (mis)representations of ‘reality’; rather they create their own ‘regimes of truth’ (Lees 2004, 102 – 3). Thus, I did not look to verify if what someone said was true or false, rather I sought for the subtleties and meanings that were being conveyed by people’s beliefs, expressions, and discourses surrounding the issues. For example, when Añawayans talk about going to the clinic, they

are not only talking about visiting the clinic, but they are also speaking of the relationships and interactions with health professionals that take place in the space of the clinic, where they are powerless in the face of the well-to-do authorities who represent a history of elitism and oppression (Koss-Chioino 2003).

Being interested in cultural aspects of the use of medicinal plants, my assumptions that the use of traditional medicine and medicinal plants occurred in the past led me to seek stories about the past. This was based on my assumption that such stories would tell me something about how people thought of medicinal plants. My assumptions did not hold. Añawayans told me they did not have any legends or myths about medicinal plants from the past, nor was there a specific way that people were initiated into lay medicinal plant knowledge. On most occasions I was told such stories did not exist, and on some occasions I was told they had been forgotten. Although I knew intellectually that 'culture' (if one can create such a category) is not static, and not a preserve of the past, I had not internalized this completely until I realized that the stories people were telling me *were* indeed stories about their culture. The discourses surrounding medicine and health do indeed impart cultural information, and can serve metonymically<sup>18</sup> (Conner 2001) to express how they deal with rapid transculturation, monetization of their economy, the introduction of modernity including institutional services and modern technology. While this may seem obvious, and is obvious to me now, this experience led me to understand this on a level beyond the intellect.

With this in mind, I identified a series of themes for each set of interviews. I coded each interview and organized the data in Microsoft Excel, by colour coding each theme, and making a subset of themes. This information was compiled and analysed in an inductive manner. I wanted the people I interviewed to express what issues were important to them,

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<sup>18</sup>A metonym is the substitution of one word for another with which it is associated.

and not restrict their responses to my previously held assumptions. After coding the interviews, I reread each interview as I wrote to verify my ideas and look for further understanding of the issues.

### **3.3 Positionality**

In this section I discuss the positionality of my research participants as well as myself. Positioned on several axes of difference including gender, race, ethnicity and class, my research participants and I were influenced by each other's identities, which certainly affected our relationships and thus influenced my informant's responses. Such axes of difference become significant tools in power relations, a lesson I learned all too well during my research. This section speaks to the influences my position as a white, middle class, female academic of occidental origins may have had on my interactions with my research participants and thus my research.

As a result of my position, my interactions with city people compared to those in rural communities were different. In the city, I was at various times, sought out, attributed high status merely because of skin colour, and approached because of the assumption that being a white foreigner meant I was wealthy and therefore may be able to donate funds to whatever project or organization they were working with. Although I was not affiliated with any known organization (Simon Fraser University is largely unknown in Perú), many doors opened for me that I did not expect. For example, I visited a CLAS clinic in Cusco that had an interesting medicinal plant garden that they were hoping to elaborate for the use of patients. I asked the secretary at the entrance if I could set up an appointment with someone involved with medicinal plants. Within minutes I was escorted into the director of the clinic's office, who was extremely magnanimous. I told him about my research interests.

He then stated his interest in my working with the clinic, and diplomatically inquired about the possibility of me funding the hospital in some way, or seeking funding in Canada. After I assured him I could not, I was quickly dismissed to the medicinal plant technician, who gave me a tour of the plants. It was not the only time that my identity was mistaken for someone who would provide financial support. In other cases, I was awarded unwarranted prestige and status. Being ushered into the doctor's office for an interview while patients waited for them exemplifies this.

In Añawi, while the *campesinos* have a strong sense of cultural identity, they have also faced denigration by the state, institutions as well as people of European descent. For example, there was a television show in Perú that ended not long ago that featured a little *campesina* girl, and depicted her trials and tribulations with life in the 'modern age'. She was characterized as naïve and simple-minded, which served to reproduce such categorizations. There are countless jokes told by those of European descent featuring *campesinos*, which also denigrate and serve to reproduce such feelings. It has been noted that in the Andes, researchers are often categorized as "well to do professional persons with light skin... [and are] identified with the oppressive elites of the society" (Koss Chioino 2003, 20). Thus my position in their community as a white woman in my thirties, researching and travelling alone without husband or children unsettled some of them. They were at various times curious, mistrustful, resentful or inquisitive. At other times, I was regarded as 'other'; children stared at me and chased me down the road, adults were sometimes shy or mistrustful of me.

My position in regards to my gender was also a subject of puzzlement in the rural community. For example, one day I was walking with my guide when an older woman saw us approach and started laughing and pointing at me, talking rapidly in Quechua to my guide. My guide told me the woman found me very strange, because I was wearing pants and a shirt

like a man, but I had braids, and therefore, must be a woman. On other occasions my position appeared to cause melancholy and resentment in some women. In one such case, I was interviewing a woman my age that had 5 children, and was visibly fatigued. It was one of my first interviews, and I was trying to be sympathetic to my research informants, thus when she told me her age, I replied that I was the same age. She looked at me in a way that I could only interpret as sadness, and she asked me later in a pleading manner about family planning. It was this event that impressed upon me the most the role that positionality plays in research.

In many cases, I found that women responded to me differently if their husbands were present. While this may also be due simply to personality differences, I witnessed on several occasions that after speaking some time with a woman, her attitude would change if her husband arrived in the middle of our interview. On such occasions she would begin speaking freely and openly, becoming hushed and submissive with the presence of her husband who invariably spoke on her behalf, even answering questions directed to his wife. For example, at the beginning of one interview, my (female) research participant offered me a comfortable chair to sit in, while she sat on a sheepskin on the ground. Trying to be respectful of the fact that it was her home and that she was perhaps 20 years older than me, my cultural background led me to insist that she occupy the more comfortable chair. She eventually took the chair, and a lively conversation ensued. After about an hour, her husband arrived home. He ordered her to sit on the sheepskin and give me the chair, occupying his own comfortable chair, and then proceeded to answer the questions on her behalf, not allowing her to voice her opinion.

In another situation, after attending an IEPLAM meeting, I helped a group of five ladies pick camomile, and after a few minutes we started to chat comfortably. I had

interviewed all of these women previously, and now that they were together as a group without their husbands, the conversation became lively, and they asked me very personal questions about what kind of birth control I used, and asked if I was married. They joked bawdily about sexual topics, male genitalia and family planning, which I do not believe would have happened in the presence of men. Furthermore, it was this interaction that informed me how important a topic family planning was in the community, and led me to set up a new set of interview questions on this topic. I found some women on other occasions to be extremely shy with me, whether their husbands were present or not, which elicited in me the unexpected emotional response of anger and frustration. While I was careful not to display this, I felt shamed about my very human response while wearing the hat of the researcher. I later concluded that the anger I felt was more sadness in witnessing what I guessed to be a result of my position of power in relation to them.

My identity was mistaken in Añawi on several occasions. I was sometimes asked if I was Peruvian (Spanish was also a second language for Añawayans; could it be that they did not detect my accent? Was it merely a way to break the proverbial ice to then ask me where I came from?). I was also asked if I would make a donation to the community, or if I could tell the 'officials' that the community need money and financial support. On four occasions, I was asked by mothers to be the godmother of their child. I learned later that this is a common request of westerners who get to know Peruvians, especially in the low-income sectors as a way to secure help in the form of gifts or money for their children. Not being prepared for the responsibility, I politely declined each request, explaining that I did not have a fixed domicile, and was unsure whether I could assume this responsibility.

For these reasons, I will never be sure about the answers to my questions. Would someone else elicit a different response from them? Regardless, their answers contained



information beyond what they told me literally about how they wanted to be perceived by me, the identity that they wanted to portray to a foreigner. Their narratives offered me a perspective of themselves that they were comfortable giving me, and which served to (re)produce how they wanted their lives, their relationships, their identity to be understood and perceived. Accordingly I do not claim to construct an exhaustive or 'truthful' representation of my research participants' experiences.

Trust was difficult to establish particularly among the campesinos, and I do not assume that it was established. There may have been moments of trusting, in particular outside the formal interviews when they felt comfortable to ask me questions. These moments often happened at times when we were carrying out small tasks, for example preparing meals or picking plants. The president of the Committee on Medicinal Plants invited me to have dinner with his family on several occasions. The first meal they made for me was typical of small town restaurants for foreigners or city people (rice, fries, a piece of meat or chicken, tomato and onion). I noticed that before my arrival, the family had eaten the more meagre typical food of wheat or corn soup and dried potatoes<sup>19</sup>. I told them that I was very grateful, but that the next time I ate with them, I would prefer to eat exactly what they were eating, and remarked on how tasty it was. We shared several meals like this, and it seemed to please them that I liked their food. As we ate they would try to have me say Quechua words, and as I bungled them, the family would all burst out laughing. These more 'intimate' moments, without the tape recorder and interview in hand, led to a more trusting relationship and long conversations about the different worlds we lived in. Vicente would ask me to clarify uncertainties he had about the world outside of Añawi, 'where do cars come from? Is China and Japan the same thing? Is Israel a country or a city? How does a

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<sup>19</sup> Commonly known as *chunyo*, these are potatoes are frozen and dried in the strong Andean sun in order to preserve them. The process turns them black.

radio work?’ I was touched that he felt comfortable to ask me these questions, and Vicente was very helpful in answering my questions about his way of life that he probably thought were very silly.

I spent the most of my time in Añawi with my guide and translator, and I felt that our relationship developed the more time we spent together. Her answers to my questions became more complex, and the issues we spoke about the first day became multiplex as we revisited them. For example, the first day we worked together, she told me about how wonderful it was living in the country and that people were happy there, they ate only natural foods, and they never became ill. She painted a bucolic and romanticized picture of her life in Añawi. As time went on and our trust grew however, I realized her view was much more complex, and I learned that indeed, people do become ill and die, not everyone is happy all the time, and that when they can afford to, they eat refined and sugary foods (natural foods are what they grow in Añawi, and what they must eat as they are subsistence farmers). This relationship was very valuable and demonstrated how layers of meaning can be uncovered with more trust and involvement with people.

### **3.4 Conclusion**

This section addressed the methods I used in my research. I drew on the ethnographic techniques of semi-structured interviews and participant observation in order to facilitate a connection with my research participants. Research projects where power relations inevitably abound raise the question of representation. I attempted to reduce this by allowing my research participants to inform me what the important issues were. Ethnographic techniques allowed for this by facilitating an exploratory approach and flexibility. I approached my data analysis by drawing on discourse analysis, which allowed

me to explore the layers of meaning that accompanied my research participant's discussions.

Finally I consider positionality in the context of this research.

## **Chapter 4:** **Health Care Reform in Perú** **and the *Comités Locales de*** ***Administración de Salud (CLAS)***

### **4.1 Introduction**

The following chapter will address the establishment of the CLAS system. The following is in part a review of the limited available literature written about the CLAS and in part an account of the research I conducted in two different CLAS clinics near Cusco. I argue that despite the fact that the CLAS program appears to have many aspects of comprehensive PHC it more closely resembles selective PHC. While comprehensive PHC is characterized as low cost wide-ranging health care accessible to low-income and otherwise marginalized people, selective PHC is characterized by easily monitored vertical programs, a focus on disease and technology, and by “efficiency” trumping social solutions to ill health. I argue further that in its current model the CLAS program cannot fulfil its original goals. My research provides support for this claim, and also looks at the experiences of people whose health needs the clinic serves.

### **4.2 Health reform in Perú and the CLAS program**

Health sector reform took place to varying degrees in different countries in Latin America after the economic crisis of the 1980s. Through the reforms, the international funding institutions intended to increase user satisfaction and equity through the provision of a basic package of services based on what each country could afford (Homedes & Ugalde

2005). Increased economic efficiency trumped all the other objectives (Cortez 2000), which resulted in significant cutbacks in social spending in general that were particularly harsh on the low-income sectors (Asthana 1994).

Health reform in Perú began in 1991 under the Fujimori government through the introduction of user fees (Ewig 2000). The user fee is a flat rate that each person pays for consultation with the doctor. The health system, like the rest of the economic situation in Perú (Bowyer 2004), was in shambles when Fujimori was elected in 1990. At the time, the Health Ministry's budget was only 15% of what it was in 1980 (Ewig 2002). While health spending in the 1970s and 1980s was plentiful, it was mainly focused on urban hospitals and what remained was inadequately geographically distributed (Ewig 2002), which added to the ever growing health disparity among the poor and the rural. Fujimori was not interested in social policy, thus the health reform was more reflective of the economic crisis than it was a desire for the improvement of the health system (Ewig 2002). Consequently the reforms were more centred on efficiency than on equity (Iwami & Petchy 2002). Though Perú's reforms were characterized as some of the harshest in Latin America (Ewig 2000) they were largely typical of other Latin American countries, and carried similar objectives of increased coverage, decreased inequality, decentralization and local participation (Iwami & Petchy 2002). The health care system in Perú has typically followed a segmented model where the various actors of the health system (private sector, Ministry of Health, and institutes for social security) are isolated and operate in a vertical manner (Londoño & Frenk 1997) so that public and private institutions serve specific sectors of the population (Altobelli 2000). Thus health provision is divided by social sector instead of function. Accordingly, private health insurance is provided for civil servants and the government has traditionally funded primary

health care for low-income sectors of the population. For the purposes of this chapter, the focus will be on the phase of reforms that pertains to primary health care.

Primary Health Care in Perú is implemented through the Ministry of Health's Basic Health for All Program (*Programa de Salud Básica Para Todos* – herein referred to as “Basic Health”) which was inspired by the WHO's ‘Health for all by 2000’ approach declared at Alma Ata in 1978. However, due to reports revealing that 70% of the poor were unhappy with the services offered through Basic Health (Cortez 2000) and the fact that large sections of the population were still plagued with diseases of the poor, (Altobelli 2000) such as cholera, TB and diarrhoea, there was a perceived need to improve PHC initiatives in the early 1990s. Built on the philosophies of the Basic Health (Iwami & Petchey 2002), the CLAS program was born as a pilot project in 1994. The CLAS is financed by the Ministry of Health through the Basic Health program (Altobelli 2000) and though they are inextricably linked, they compete in policy-making (Ewig 2002). The CLAS is considered to be a popular response to the restructuring of the health system (Iwami & Petchey 2002) demonstrated by the fact that in 1997 (only three years after the CLAS pilot started) 12% of the health posts were run by CLAS (Iwami & Petchey 2002) and by 2001 this increased to 25% of all the primary care clinics (Altobelli 2002). In 2004, this increased to 35% (Future Generations 2004), representing a significant increase and user satisfaction has been reported to be high (Cortez 2000).

There are fundamental differences between the CLAS system and the Basic Health program that are significant for this discussion. The Basic Health program is administered centrally and more closely resembles the philosophies of comprehensive PHC. By addressing issues such as low-income health care, decentralization, community participation and cultural sensitivity, the CLAS program appears to be a unique response to health sector

reform considering that reform usually results in a selective approach to PHC. However, I argue that it more closely resembles selective PHC.

In its original mandate, the CLAS initiative had elements of comprehensive goals through its attempt to service the PHC needs of the poorest members of the population (Government of Perú 2000), broaden PHC coverage for the economically marginalized rural and urban populations, improve the quality of treatment, prioritize social programs, and reduce poverty (Cortez 2000). In fact, in order to secure more loans, the government of Perú has presented the successes of the CLAS initiative to the World Bank as proof of Perú's prioritization of social programs and structures in their aim to reduce poverty (Government of Perú, 2000). In addition, through the CLAS initiative the Ministry of Health bestows more power into the hands of local people through the process of decentralizing, which is a ministry wide policy (Iwami & Petchy 2002, Ministerio de Salud 2003). As part of the decentralization process CLAS clinics are legally private, not for profit entities (Altobelli 2002, Ewig 2002). The clinics rely on the participation of elected community members for the administration of the clinic, making it appear like a grassroots initiative. With the communities gaining more control of the clinics, it is thought that this would empower local peoples as well as increase fiscal responsibility (Altobelli 2000, Cortez 2000, Noel 2005). Furthermore, by responding to the health reform objectives of decentralization and local participation, proponents of the CLAS believed that equality, coverage and the quality of primary health services would be improved (Altobelli 2000, Cortez 2000). However, while it appears that the CLAS is a positive step in terms of achieving the comprehensive goals set out by the Alma Ata Declaration, it is not without its critics. This section will examine this perceived advantage of the CLAS system through the use of the little available literature on the CLAS system as well as through my own research.

In particular it is important to examine how the CLAS system fits the paradigm of Primary Health Care. In what ways does the CLAS system fulfill the goals of PHC? To answer this question, it is important to examine the use of CLAS clinics at the local scale.

#### **4.2.1 A Local scale look at the CLAS program**

In the literature there are no local scale qualitative studies on the use of CLAS clinics by lay people. Qualitative studies, while difficult to be generalized, can offer a rich account of complex layers of meanings of social processes. Such an approach may yield insights into how people experience the CLAS, to what extent they use the CLAS for their primary health needs, and as such may indicate to what extent the CLAS is fulfilling its goals of comprehensive PHC. I wanted to speak to people in a rural setting who have access to a clinic about their perceptions and experiences of the clinic to gain some indication of whether the CLAS was broadening its coverage to rural sectors that are also low-income, and whether this contributed to a strategy of poverty reduction. I asked a variety of questions about their views of the CLAS clinic in order to better understand what influences some people's use of the CLAS clinic, and what possible barriers to its use are. Their answers may offer some insight into how the clinic may be better utilized and more accommodating for local peoples.

To guide my interviews, I started off by asking the villagers what they do when they or their family members fall ill with a variety of common ailments, such as colds, the flu, or gastrointestinal problems. All of them initially responded that they use medicinal plants (this will be further discussed later in this chapter and in the next chapter). I then asked if they went to the clinic. Out of the 29 people I asked, 59% (17 of the 29) said they only use plants to heal, even when they were very ill, and 41% (12 out of 29) responded they go to the



CLAS clinic when their illness was grave. Of this 41%, however, many qualified their answers. Some said they went because they were obligated to take their sick to the clinic, some complained that although they sometimes went, the CLAS was too expensive or that going to the CLAS and taking pills did not actually heal their illness in the end.

The place and space of the clinic itself is also important to consider for this discussion. Clinic B is very simple, painted in white and hospital green. On the walls are various posters that promote campaigns and programs, which in a bright and lively (and sometimes euphemistic) way encourage people to come to the clinic, or follow various instructions concerning their own or their children's health. There are also many graphs and statistics on the walls, depicting the health status of the communities they serve. Several smaller rooms and offices, including two doctor's offices, a dentist office and obstetrician office, surround a central waiting room. The doctors and health care workers wear white lab jackets over their professional civilian clothes. The people waiting are for the most part *campesinos* from the surrounding villages that sit quietly waiting their turn. Although the doctors did not appear overly busy, there were always people waiting to see them.

The CLAS system has undertaken several initiatives to address issues common to PHC efforts. Such initiatives include poverty reduction, decentralization, community participation and cultural sensitivity, which are said to increase PHC coverage and empower local peoples. How does the CLAS program foster cultural sensitivity? The CLAS has a guiding principle of poverty reduction: how does the CLAS operationalize this principle? Has decentralization led to increased community control of CLAS services? How has community participation affected the CLAS program? Also, what are the barriers to the CLAS being able to broaden its coverage to the population of Perú? The following section will discuss these issues with data from case studies of two CLAS clinics.

#### 4.2.1.1 Cultural Barriers

The cultural differences between the Añawayans and the health workers in the CLAS clinic are reflected in the interactions that take place during clinic visits, as well as through the discourses of health workers and community members. The introduction of western styled PHC with its epistemologically different views on health, healing and nosology (Popay & Williams 1996), has influenced community health practices, but it has also faced a number of barriers and has never gained true hegemony over local medical systems. Underlying power relations, and also cultural differences, especially as they pertain to health practices, influence the interactions that occur in the clinic. In this discussion, I step away from the premise that ‘medical systems’ are definable entities and suggest that such categorizations should be merely used as a tool to analyse certain phenomena. As such, I suggest that there are a collection of processes, relations and interactions between people at the point of access of the various medical practices. This premise is the backdrop of this discussion. Therefore, to understand the local scale and ‘everyday’ interactions between PHC clinics and locals, it is important to consider the cultural context of the actors within this relationship.

As previously mentioned, all my informants in the village told me that when they become ill<sup>20</sup>, they use medicinal plants to cure themselves. In fact, my questions about how people cured themselves were often met with a litany of medicinal plants or plant preparations that have been passed down from their parents, grandparents and other sources. Both men and women in this village are accustomed to looking after themselves and their family members in the case of ill health, as opposed to seeking alternative care.

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<sup>20</sup> The most common illnesses in the area are respiratory illnesses, colds and the flu. Many also complained of gastro-intestinal problems, headaches and toothaches. I asked primarily about these illnesses.

Owing to this tendency, medicinal plant knowledge represents a rich and place specific cultural heritage that is a significant factor contributing to Andean cultural identity.

Despite the rich practice of medicinal plant use and different understandings of health embedded within the Andean tradition, attempts to address cultural differences between locals and the clinic appear to be limited to requiring doctors and health care workers to speak Quechua (though in my sample, not all of them did) and allowing traditional birthing techniques to be practiced in the clinic. That being so, nothing has really changed in terms of health care delivery since the care in the clinics remains to be based purely on biomedicine, in spite of the fact that one of the goals of PHC was to offer more space to the use of low cost traditional medical techniques. The health workers I interviewed admitted they were well aware that many of their patients still rely on traditional medicine and mainly medicinal plants. However, many of the health workers I interviewed derogated the use of medicinal plants, referring to them as little more than a 'cheap alternatives' if people cannot afford to purchase pharmaceuticals. Very few of the health workers in my sample thought that local medicine used by their patients was effective, and the common attitude towards it can be characterized at best as 'tolerance'.

To illustrate, I asked an official in Lima (Interview 209) whether traditional medicine and specifically medicinal plants were used in the CLAS clinics. First he indicated that the clinics use both traditional and biomedicine, and that the traditional complements the use of biomedicine. When I asked only about the procedures in using traditional medicine, he specified that actually they accept that traditional medicine is used outside the hospital, but

they don't use it in the hospital, and that if someone wanted to "*pasar la cuy*"<sup>21</sup> there was no problem. There are a couple issues to address here. First of all, the assumption with this statement is that CLAS system presumes power over the locals by saying they accept this practice, when it does not take place inside the realm of the clinic. What if they did not accept this practice? How could they control it? It is also interesting that this doctor refers immediately to the almost cliché practice of guinea pig diagnosis<sup>22</sup>. The use of guinea pigs as a diagnostic tool is undoubtedly widespread, but even more widespread is the everyday use of common herbs to heal common illnesses. Most importantly, guinea pigs are used to diagnose culturally bound illnesses<sup>23</sup>. According to the villagers in my sample, people do not go to the clinic to heal such illnesses, as it is their opinion that medical doctors do not know how to cure them. This stereotypical reference to the use of guinea pigs suggests a lack of understanding of the complexities of traditional medicine in the Andes, or a romanticized vision that fetishizes practices that outsiders see as the most bizarre, or the most "other".

It follows that when they consider the continued use of indigenous medicine, doctors and health care workers I interviewed claim that the *campesinos* are stuck in their ways, loath to comply with biomedical practices, and resistant to change. However, in her research on '*compenedores*'<sup>24</sup> in the Andes, Oths (2003) notes that the empirical tendency of Andeans actually leads them to be very flexible in terms of incorporating new technologies

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<sup>21</sup> Directly translates to "pass the guinea pig". This refers to the shamanic practice of holding a live guinea pig (*cuy*) by the hairs on its stomach, and rubbing it over the body of the patient who stands with her/his arms outstretched, so the shaman can rub the guinea pig over the main parts of the body. The guinea pig is then killed and opened, and its entrails read for the purposes of diagnosing the patient.

<sup>22</sup> Guinea pig diagnosis is widely known about even outside Perú, and films of its practice are often showed in undergrad anthropology classes.

<sup>23</sup> Cultural bound illnesses are those illnesses that do not have a common counterpart in biomedicine. Common examples are *mal viento*, *mal ojo*, *susto*. Such illnesses are commonly thought to be caused in the spiritual realm rather than by pathogens, and may have symptoms that are common to a variety of different biomedically recognized maladies.

<sup>24</sup> *Compenedores* are similar to *hueseros* or bonesetters.

or medicines if they really help. As such, she concludes that since the *componedores* have persisted this long through the pressures of modernization, their practices must be effective. Another interpretation of ‘resistance to change’ is more appropriately attributed to risk aversion<sup>25</sup>, and this lack of understanding is another important factor that may lead to under-use of CLAS clinics. While policies within the CLAS may attempt to address cultural awareness, they appear to address factors it can most easily attend to, while ignoring other important factors. It is important to examine these efforts as well as to look at other cultural aspects that affect people’s health care seeking decisions. Qualitative, local scale methods are well designed to interpret these issues.

Many *campesinas* do not speak Spanish. Many of the women in my sample that were over the age of 30 had very limited education, and only spoke Quechua<sup>26</sup>. This presents a significant barrier for them when going to the clinic, even though the prerequisite to be employed by a CLAS clinic is the ability to speak Quechua. At the time of this research, most of the doctors and health workers did speak Quechua and there were still health workers, from before this prerequisite was enforced, that do not speak or speak very little Quechua. In my sample, at least one doctor did not speak more than a couple of words of Quechua, and there was evidence that some health workers did not speak Quechua at all. In most cases younger members of their families who did speak Spanish accompanied patients

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<sup>25</sup> It has been noted among external policy makers and organizations that Andean people do not comply with community ‘capacitation’ projects, or abandon projects at the last minute returning to the safer endeavour of agriculture. Cáceres Ch. (2002) has interpreted this aversion to risk as a preference for security. The inhospitable geographical and climatic conditions of the Andes favour agricultural actions that focus on security and safety in the interest of household survival (Graham 2003). This also necessitates rapid changes in plans just as often as resistance to external change, and risk aversion.

<sup>26</sup> Most women in their early twenties and younger are able to speak Spanish because they have attended school. They also have a stronger desire to leave the village for the more modern city. Very few of the women over 27 or 28 years old were able to speak Spanish and those that did spoke very little broken Spanish. The women that lived at lower altitudes of the village, and thus closer to the town were more likely to speak Spanish.

who did not speak Spanish, and the interactions with health workers took place in Spanish. Of the examinations and interactions I witnessed with local people, albeit few, Quechua was only spoken once. During this examination, I overheard a doctor speak to an older lady in very simple Quechua. The doctor spoke to the woman in a very loud voice, in a high-pitched tone punctuated with diminutives, which is often reserved for speaking to very young children. Also, during a maternal and infant monitoring session, the male health care worker directed very personal questions about the mother and her health (including information on her menstrual cycles) to her husband who answered on her behalf, without consulting her, in Spanish. The doctor made no eye contact with the mother, and referred to her in third person. Several female respondents told me that they were treated poorly when visiting the clinic. When I asked them for more detail, one of the answers I received was that because they do not speak Spanish, the doctors 'insult'<sup>27</sup> them.

On the other hand, I was told about a doctor in Clinic A who was extremely well liked by the local villagers because of his caring and friendly manner. I was told that he had a great deal of respect for the campesinos, and they were very sad when for bureaucratic reasons he was moved to another community. This doctor did not speak Quechua at all, but according to one informant, was somehow able to make himself understood because he was very respectful and understanding of the Andean culture. In my observations, regardless of whether the staff spoke Quechua or not, Quechua was not heard very often within the walls of the clinic, the posters and health campaigns were not translated into Quechua. These examples imply that while the requirement that workers speak Quechua is good in theory, and may be a marketable feature to demonstrate cultural awareness, it may not necessarily be an appropriate indicator of cultural awareness.

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<sup>27</sup> I asked them what they meant by insult, and they impersonated the doctors speaking to them in harsh tones, telling them to wait, or to sit down.

CLAS focuses on cultural awareness as a means to improve maternal health and reduce cases of maternal mortality. To achieve this goal, they attempt to oblige women to give birth in the clinics, and monitor them more closely, but to entice women to give birth in the clinics they have had to accommodate traditional practices. Statistically there have been improvements in these outcomes. For example, in Perú (registered) cases of maternal mortality have decreased from 769 in 1997 to 571 in 2004 (MINSA 2004): Cases of infant mortality have decreased dramatically in the same time period, and a 70% decrease in infant mortality was predicted from 1994 to 2004 (PAHO 2005). However, despite these improvements, in 2000 there was still a dramatic difference between the national average of professionally monitored births (50.3%) and the rural average (28.7%), which implies that there still exist barriers for rural women to have medical attention during birth (PAHO 2002).

Nevertheless, from my observations in Clinic B there was some indication that this had changed from the year 2000 to 2003 in that region. The obstetrician I interviewed (Interview 206) informed me that in the year 2000 she only assisted in 20 to 30 births in the clinic, while in 2003 the number had increased to 160. While these numbers do not give us a percentage of births that took place in the clinic as opposed to home, the increase implies an increase in professionally monitored births. The obstetrician told me that little by little they are incorporating a cultural understanding of the perinatal practices of campesinos. It was evident that she invested a great deal of time and energy in encouraging the campesino women to give birth in the clinic, to avoid problems that lead to maternal mortality. She told me that she frequently attends workshops and conferences to increase her awareness of the field. Indeed, the CLAS system has attempted to make the clinic a more appealing place for women to give birth through a variety of initiatives. They allow the father to enter the room

during birth, and they have stopped the practice of shaving the mother's genital area<sup>28</sup>. They also allow the new mother's children to spend several days in the clinic with her, since having to leave her children at home to give birth is very distressing. Finally, they allow the women to practice 'traditional birthing techniques' within the clinic. This involves nothing more than allowing the mother to squat while the husband sits behind holding her to help through the contractions rather than her lying in a supine position. Women are encouraged to breastfeed, another case in which *campesinas* are 'allowed' to practice what they did before the medical profession attempted to have them change their ways, which has proven to be superior to other methods of feeding infants, such as infant formula. While this is a step in the right direction, I argue that it can hardly be labelled a breakthrough in cultural sensitivity. Squatting during childbirth and the presence of the father in the birthing area have been widely accepted in many biomedical circles since the 1970s. Furthermore, giving birth while supine is now recognized by many medical doctors to be an unfavourable position for giving birth (Northrup 2002), and is known to be beneficial only to the doctor delivering the baby, in the case of having to use forceps or hook up foetal monitors, and more dangerous to the mother (Gaskin 2003).

In spite of efforts to enhance cultural sensitivity, there remain some barriers to women giving birth in clinics. Indeed, it has been reported that the largely rural region of Cusco has the highest risk of maternal mortality in the country (MINSA 2004). Moreover, there was some indication from my observations and interviews that many women were reluctant to both visit the clinic and give birth in the clinic. In both Clinic A and Clinic B, reports circulated of women who faced perinatal emergencies and were reluctant to go to the clinic, either because they were scared or could not make the arduous trip to town. One

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<sup>28</sup> While this has dropped out of common practice in Western countries, she emphasized this as part of their cultural awareness policy.



factor that may contribute to this disinclination is illustrated in the following narrative. I asked the obstetrician about the positive changes that she had witnessed in her four years at the clinic, to which she responded:

...[T]here has been a considerable [increase in births in the clinic] compared to years before. This is because firstly, this is an initiative that we have supported surrounding obstetric care. We try to reach the patients to impress upon them that their pregnancy is a very important situation for a woman because they are going to bring a human being into the world...[I]n this manner, we are able to make her feel like her pregnancy is important, no? [And] that her baby is extremely valuable for her, and that the birth must take place in the institution.<sup>29</sup> (Interview 206)

Such a statement includes an underlying assumption that the *campesinas* did not think that their pregnancies were important, or that their children were valuable. Larme (1997) sheds light on this type of attitude in her research, indicating that it may stem from reports of active or passive infanticide as a solution to the “absence of artificial birth control methods” (Larme 1997, 1720 – 1721) in times past. She suggests that this may have been influenced by the transformation from subsistence to a monetized economy where “differential health care allocation and selective neglect make sense” (p. 1721). However, Andean parents love and care for their children, “they nourish their children protect them from illness, abstain from physical punishment, worry when they become ill, grieve when they die” (Larme 1997, 1721). This corroborates my own observations in Añawi.

The obstetrician’s comments above reflect a lack of understanding as well as betray power relations between the obstetrician and the indigenous patients. It is likely that the indigenous women would feel undermined by such teachings, and thus have some reluctance

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<sup>29</sup> ...[S]e ha visto un censo considerable al respecto a los anteriores. Esto porque, porque uno: uno es el trabajo sostenido que se hace acá de parte del servicio obstetrix. A través de llegar a la paciente hacen sensibilizar que el embarazo es una situación muy importante para la mujer porque va traer un ser humano a este mundo...[E]n este manera llegamos a sentir a ella que su embarazo es importante, no? Que su bebe es sumamente valioso para ella, y que su parto debe estar en el instituto de salud...

to give birth in the clinic. To illustrate further, the following quote, by the same obstetrician, implies that the nature of the acceptance of traditional methods is also interwoven with issues of power:

[I]f for example the patient wants to give birth squatting...if the woman wants to give birth in this manner, we do not impose. Here, the patient gives birth how they like. So, we also *allow* the husband to come into the delivery room. Very often, we *allow* the woman to spend a few days in the clinic with her children<sup>30</sup>. (Interview 206. Emphasis added)

Such practices have been facilitated in clinics because they are understood to be beneficial to the expecting family, yet the air of tolerance demonstrated by the tone of authority in *allowing* such techniques is evidence of reification of power relations. While issues related to the facilitation of traditional birthing techniques were beyond the scope of this current project, important questions arise from the current work. As such, further investigation on relations surrounding childbirth and the CLAS needs to be conducted.

Ultimately, while statistics on maternal issues show improvements in coverage and outcomes, they mask a continued cultural discord. One important consequence of this is underlying feeling of mistrust towards the clinic especially on the part of the women. This is problematic when one considers that one of the goals of PHC (whether selective or comprehensive) is to better serve women and children. While indicators such as decreased maternal and infant mortality may signify improvements, their significance is undermined if women are uncomfortable to visit the clinic and mistrust health workers. This is even more important in a setting where there are cultural differences, and potential power relations. Because treating illness is an intimate moment, it is important for health workers to foster trusting relationships when treating their patients. In my study, I found there was a great

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<sup>30</sup> [S]i por ejemplo si la paciente quiere dar a luz de cuclillas...si la mujer quiere dar a luz así, nosotros no nos imponemos. Acá la paciente da a luz como quiere. Entonces permitimos también el ingreso del esposo en la sala de partos. Permitimos muchas veces que las mujeres se quedan muchos días acá en el puesto de salud...

deal of mistrust on behalf of the patients towards the health care workers, the result of various factors.

First of all, for a variety of reasons, many of the doctors spend very little time in each clinic, sometimes as little as a few months. It is less desirable for the doctors to work in rural areas and many take the first opportunity to take a position in an urban clinic or hospital. Such a short term makes it difficult for them to foster a long-term relationship, and therefore a relationship of trust, with the community in which they work. Other events have further debilitated people's trust in western clinics in general. As I mentioned earlier, my informants indicated that several years ago<sup>31</sup> doctors and health workers forced people to come to the clinic when they were sick rather than stay and be treated at home by issuing 'soft threats'. I was told that if they did not comply, and a family or community member died as a result of an illness that was not treated in the clinic, they would not be issued a death certificate and would face other 'legal problems'. A health worker confirmed this practice (Interview 205). The health worker avowed that from the clinic's point of view, they had an obligation to the government to collect accurate accounts of illnesses or deaths, which are difficult to enumerate if patients are not in the clinic when it occurs. In the case of death, for example, if the ill person does not come to the clinic to be treated, and dies in the village, they have to first travel to the village, and do an autopsy which results in higher costs for the family. While the clinic's perspective on this may seem intuitive, the campesinos experience this policy differently. One man explained that during this enforcement, many people died on route to the clinic because the arduous trip exacerbated their illness. The villagers who informed me of this policy conveyed a sense of obligation towards the clinic, by saying they were obliged and forced to take their ill to the clinic,

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<sup>31</sup> They were not able to tell me exactly when

implying they were not visiting the clinic by choice. Indeed this obligation appears to have fuelled some disdain towards the clinics.

A more recent breach of trust happened from 1995 to 1997. The widely reported (See Coe 2004 for more details) forced sterilization of several hundreds of thousands of indigenous women in Perú under the Fujimori regime is also a factor that has led to indigenous distrust of doctors and health care workers. During this time, indigenous women were either misinformed or uninformed about the sterilization that was performed on them in the clinic. Despite the fact that this practice no longer takes place, the consequences, memories and stories are very much alive in the minds of the rural indigenous people. As a result, many of them, especially women, continue to be wary of being treated in clinics, and employ a discourse of mistrust surrounding the use of contraception.

This deep-seated distrust has further consequences. Many people only go to the clinic when their illnesses are grave, and therefore often at an advanced stage. This frequently necessitates more serious intervention than if the convalescent had come to the doctor early. For example, in Clinic B this was often the case with tooth problems. The dentist (Interview 207) indicated that most of her practice consisted of pulling rotten teeth that could potentially have been saved with earlier intervention. As is often the case of an advanced affliction, the problem cannot be easily fixed, likely resulting in a decreased chance of positive outcome, which can also influence people's beliefs of efficacy of biomedicine<sup>32</sup>.

The way that health workers treat or care for patients also influences trust. In my sample, 32% of my informants claimed that the doctors treated them poorly in a variety of ways. An additional 18% answered that they were treated fairly or 'average', but often contrasted their answers with statements such as, "some doctors are ok, but they make you

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<sup>32</sup> Issues surrounding beliefs of efficacy of both biomedicine and medicinal plants will be discussed in chapter six.

wait.” They described the poor treatment as either being insulted by the doctors; spoken harshly to; ignored; and/or made to wait for long periods of time. Many expressed that they do not enjoy the experience of going to the clinic. Greenway (2003) reported similarly that her research participants from a rural community in the Andes were loathe to make the trek to the clinic, as it was too expensive and people were treated rudely by the clinics staff. When I asked why they thought they were treated in such a manner, some replied that perhaps the doctors had become embittered by their jobs<sup>33</sup> or that they did not want to treat *campesinos*.

The most common response to how they were poorly cared for was that they were forced to wait for long periods of time (often they said they had to wait all day) to see the doctor, and that after waiting the doctor only saw them for a quick moment. They deeply resented having to wait in the clinic, because the trip itself is long, and it results in delaying domestic duties. This is especially difficult for women, because they must constantly care for children, other family members and animals at home. Furthermore, work demands on the women in the home are steep: each hour spent away from the home represents work that she must make up later on. On the other hand, when the convalescent is at home recovering she is still able to carry out her daily duties. It was evident from my sample that waiting time at the clinic also breeds resentment.

Another factor leading to mistrust is related to fear of the clinic. One story illustrates this claim. I interviewed a woman who was in her fifties and had many colourful and rich stories. One story (Interview 107) concerned a childhood trip to the hospital to visit her father who had his leg broken in an accident. When she got there, she witnessed many of patients who were in pain; crying and screaming in their beds. She described it as a bad

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<sup>33</sup> ‘Bitter’ is often used by my research participants discourse. One can become embittered or have low moral, and fall ill because of it.

nightmare. As a child she could not figure out what sort of place could be so full of pain, and what they could be doing to people for them to be in so much pain. Her father was also afraid. He required surgery on his leg and before being wheeled away was screaming in fear that they were going to cut his legs off. This experience traumatized her to such an extent that once when she was very ill and was supposed to be hospitalized; she told her husband that she would prefer to die at home.

Some of the villagers I interviewed preferred to bypass the clinic in favour of visiting the local pharmacy. Pharmacies in Perú carry an enormous variety of prescription and non-prescription drugs. Drug regulations in Perú are slack as well, and as a result drugs that we could commonly see as prescription drugs in Canada are easily bought over the counter, with the advice of the pharmacist. In fact, pharmacists also administer some injected drugs on the premises. An advantage to visiting the pharmacy is that the service is faster than the clinic. Many different pharmaceuticals can be purchased and instructions for their use obtained in a matter of minutes.

Moreover, the pharmacies have more choice compared to the clinics (see Table 4.1). Unlike the generic brands of medicine given at the clinics, pharmacies carry products from a wide variety of pharmaceutical companies, and while the generic drugs are cheaper, the 'designer' pharmaceuticals in the pharmacies appeal to people's desire for modernity. Furthermore, the pharmacy in the clinic is not always open (there are limited hours in which one can fill a prescription in the clinic), and sometimes it does not have certain drugs in stock. Furthermore, if something beyond the ordinary is needed, patients must go to the clinic anyways. But the pharmacy is not for everyone, as the pharmaceuticals are more expensive there than in the clinic. In some cases, people sell their animals or extra produce to be able to purchase pharmaceuticals in the pharmacy. In a case I mention earlier, a family

was in financial straits after a fever affected their whole family. Rather than going to the clinic, they visited the local pharmacy.

Table 4.1: Available medicines in Clinic B

Medicine	Concentration	Form	Price per unit (in PEN)
Amoxicilina	500 mg	Tablet	0.172
Amoxicilina	250 mg	Tablet	0.117
Amoxicilina	250 mg / 5 ml	Serum	1.663
Amoxicilina	125 mg / 5 ml	Serum (60 ml)	1.284
Paracetamol	500 mg	Tablet	0.027
Paracetamol	120 mg / 5 ml	Liquid	0.963
Paracetamol	100 mg / ml	Solution	0.756
Ibuprofin	400 mg	Tablet	0.031
Ibuprofin	100 mg / 5 ml	Serum	1.176
Dicloxacilina	500 mg	Tablet	0.295
Dicloxacilina	250 mg	Tablet	0.224
Sulfametoxazol + Trimetoprima	800 / 160 mg	Tablet	0.080
Sulfametoxazol + Trimetoprima	400 / 80 mg	Tablet	0.080
Sulfametoxazol + Trimetoprima	200 / 40 mg / 5 ml	Serum	1.023
Eritromicina	500 mg	Tablet	0.272
Clotrimazol	20 g / 1%	cream	0.882
Diclofenaco Sodico	75 mg / 3 ml	Serum	0.225
Clorfenamina Maleato	4 mg	Tablet	0.021
Mebendazol	100 mg	Tablet	0.049
Mebendazol	100 mg / 5 ml	Serum (30 ml)	0.954
Albendazol	200 mg	Tablet	0.080
Albendazol	100 mg / 5 ml	Serum (20 ml)	0.722
Metronidazol	500 mg	Tablet	0.054
Lidocaina Chlohidrato	20 ml / 2%	Serum	1.260
Disposable Syringe	5 cc	Unit	0.260

adapted from author's photograph

In spite of the fact that many of the locals use pharmaceuticals, however infrequently, they tend to denigrate pharmaceuticals, which seems to stem from past problems with pharmaceuticals, or the harms that pharmaceuticals have caused. Medicines also serve as metaphors and may have multiple and complex meanings (Miles 2003, Van der Geest 1989), and by denigrating pharmaceuticals *campesinos* are also speaking about their

relationship with modernity. Some people told me that out-of-date pills from western countries were purposely sold in clinics either to cause them harm or out of spite. The fact that this discourse is reproduced affects the current perception and consequently the use of pharmaceuticals.

To illustrate, at some stage in my interviews I realized that a very important topic to my female informants was contraception. I unfortunately did not have to time to explore this issue to more depth, because it is a sensitive topic, and the women only felt comfortable speaking to me about it as we got to know each other better. However, it is a very salient topic that requires further research. During my interviews, some women started to ask me how I 'took care of myself'. It took me a little while and some detailed explanations to find out that they were asking me what kind of contraception I used<sup>34</sup>. I was informed that the clinics previously issued free contraception, but now they are billed for contraception and the women find it expensive. There are suspicions among the women that they were given birth control pills and Depo-Provera that had passed their expiry dates, and were consequently ineffective because some fell pregnant while using them. Others told me they tried the IUD, but stopped because it caused headaches and other problems. Many were discouraged by these results because they realize as their economy becomes more and more monetized they cannot support as many children as they have. They did what the clinic told them to do, and it failed. Although there are many outlying factors as to why the contraception did not work, including missing pills, and incorrect use, they housed this discussion in a discourse of anti-modernity. The women I spoke to specifically about birth

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<sup>34</sup> This was a legitimate question in and of itself, and it also masked the other question of "why are you the age you are, travelling around by yourself with no children?" Most women my age in this village had at least three or four children, if not more.



control were interested in turning back to the ways of their grandparents and ancestors, and learning about using plant forms of contraception.

Many of my informants told me that pharmaceuticals could actually aggravate an illness, or cause more damage, and that sometimes they could actually kill a person – especially children. Another way that people described pharmaceuticals was that they were '*calmantes no más*', that they are 'calming and nothing more'. When I asked what they meant, I was told that pharmaceuticals only really take pain away from an illness, but they do not cure it, and that if you take pharmaceuticals for something, you may feel a little better for a while, but the illness is still there and comes back later on. They believe an illness is not cured by pharmaceuticals in the way that medicinal plants can cure an illness, in contrast to health care workers who believe the reverse.

Interestingly, I found that the more I questioned, the more contradictions there were. Many people who claimed that pharmaceuticals only caused further harm actually used them once in a while when medicinal plants did not do the job. In spite of this, most of my research informants turned to medicinal plants first, and only when they failed to help would they turn to pharmaceuticals. Consequently the local indigenous people were not 'stuck in their ways' by refusing to go to the clinic or seek help outside their medicinal plants. When illness strikes, they will do everything in their power to cure themselves, even if it means sending their family into debt by purchasing pharmaceuticals. At the same time, most of them were making a conscious effort to return to using medicinal plants for their health needs.

Finally, cultural discord is a large factor that leads to under-use of CLAS clinics. At the same time, the Andean culture is not foreign to many of the doctors and health workers. Some of the health workers I interviewed were brought up by their grandparents who spoke

Quechua in the home and practiced indigenous healing techniques. In several cases, it was this apprenticeship with their grandparents that inspired the health workers to become doctors and nurses. Most of them had at least some knowledge of traditional medicine, especially medicinal plants, and were very interested in speaking about them. However, although the health workers in the CLAS make a concerted effort to foster trust and cultural awareness, their efforts appear only marginally effective, and numerous memories of past misdeeds still haunt *campesinos'* minds and colour their discourse. The rare doctors that do stay in the communities have started to gain people's trust. However, with events such as the forced sterilization by the Fujimori regime, obligations to go to the clinic, and assumptions surrounding childbirth, it is understandable why many remain reluctant to go to the clinic, and cultural barriers still appear to influence CLAS use in rural areas.

#### 4.2.1.2 Poverty Reduction

One of the CLAS' original and most important goals was to provide PHC for the poor. In its *Letter of Intent* to apply for funding from the IMF, the Government of Perú (2000) included the CLAS as part of its poverty reduction strategy. However, it is important to examine in what ways the CLAS provides a suitable platform for poverty reduction. To contextualize this discussion, each CLAS is legally a private, not for profit entity (Altobelli 2002, Ewig 2002) that has six community members, half of which are elected by the community, while the other half are appointed by the manager of the CLAS who directs administrative duties (Cortez 2000). While the CLAS is still dependent on the state for salaries for the doctors and a core of health care workers (Ewig 2002, Iwami & Petchey 2002) the CLAS keeps the revenues it gains through user fees and prescriptions and uses them to pay overhead costs. The revenues are reinvested back into the CLAS to make the

clinic more attractive by hiring specialists or purchasing new technology, thus generating more income. All of the CLAS workers I interviewed emphasized that the fact that the community is responsible for its own resources was the strongest advantage of the CLAS system. The CLAS obtains the pharmaceuticals it sells to patients from the Ministry of Health (*Ministerio de Salud* or MINSA). They are purchased in bulk, generic form in order to keep costs down. Also, like many health services that have undergone neoliberal health reform, the CLAS charges user fees. These vary from two to three PEN, and there is a system in place to protect the poor from these fees.

The fact that the CLAS clinic is a legally private entity signifies that government resources only pay for doctors, nurses and technicians, and user fees meet all of the clinics' other financial needs. This can be a potential threat to their survival depending on the economic status of the neighbourhood or town where they are located. While the user fees are designed to finance the CLAS, they result in placing clinics out of the reach of the poorest. Whereas the fees accord the clinics more fiscal responsibility and independence, they are an important impediment to one of the CLAS' most publicized goals of providing services for the poor.

The cost of user fees is perceived very differently by the doctors and government compared to the local campesinos who rely on the clinical services. When I asked CLAS workers about the price of treatment and prescriptions, they responded that they were very affordable; that they ranged between two and 20 PEN and that each pill only costs a few cents. One doctor (Interview 202) emphasized that they were so affordable because they were subsidized by the state and that otherwise they would be well beyond the means of the people. One health care worker (Interview 205) said that currently, with all of the programs and free services the government supplies, people are moving away from the attitude that

they cannot come to the clinic because they do not have the money, because, he says, medicines are within the means of everyone now. Among the doctors I interviewed was a feeling of benevolence towards the community because of the low cost services they were able to provide.

Although the user fees appear to be very inexpensive from the perspective of the CLAS workers, they can represent approximately 10 – 15% or more of a family's weekly earnings, when indeed the family has any earnings at all. Furthermore, there was a discrepancy between what the doctors told me a visit to the doctor cost, and what the villagers told me. Some people of the village told me it cost 20 PEN to go to the clinic and have everything done that they want you to, and others claimed the prices were closer to 80 PEN or hundreds of PEN. They were aware that the consultation fees were only 2 or 3 PEN, but complained that the doctors always sent them to do tests that cost money, and that pharmaceuticals often had to be purchased at a pharmacy because the clinic did not have them in stock. Doctors did not inform me of these possible extra costs. When I asked one man if he goes to the CLAS clinic, he said they sometimes go, but every time they do, it takes money away from the family (Interview 113). The villager's capital is often wrapped up in livestock, which they sell when they need to access certain social services, or make necessary purchases, such as pharmaceuticals. Such a financial coping strategy can be very precarious as some families may be forced to sell many of their assets in the case of family illness. Indeed an illness can send a family into a spiral of impoverishment (Janes 1995). For example, the family of the woman I hired as my guide had been economically devastated by a severe fever that affected many of its members. They initially used medicinal plants to treat the fever, and when this failed, purchased pharmaceuticals that were beyond their means. After working with me for a few days, this story emerged. She was happy that I had

hired her, because her family was experiencing economic hardship and had to rebuild their resource base.

As an attempt to counteract the high costs of treatment, the administration of the CLAS argues that the profits from user fees gives the CLAS the ability to offer free consultation for the most needy (Cortez 2000, Iwami & Petchey 2002). However, when the clinic assumes certain financial obligations by being a business, it is not in its interest to provide this service liberally. Furthermore, the campesinos I interviewed did not appear to be aware of this option, even though they all claimed it was too expensive for them to go to the clinic. Only one person from my sample admitted to having her fees exempted (Interview 122). She had been gored in the chest by her cow, and not having money to pay the doctor, tried to pack the wound with medicinal plants. When that did not ease her pain, she made the trek to the Clinic B. After being refused treatment because she had no money, she threatened the doctor that she would die right there in his office if he did not treat her. Apparently the doctor acquiesced. These examples imply that while in theory the poor can be exempt from paying clinic fees, it was not widely publicized in the clinics I researched seeing as they must run a profit in order to survive as well as be competitive.

On the other hand, there is another government-subsidised program that is available for the extreme poor: the SIS (*Segura Integral de Salud* – Integral Health Insurance). People pay 1 PEN for this insurance, which has five different plans; two for children aged 0 to 4, 5 to 17, one for pregnant women, and two others for adults. The SIS provides basic health services such as emergency attention, hospital stays, medicines, and laboratory analysis. I discovered this insurance plan accidentally. One of the first doctors I interviewed (Interview 202) informed me of an insurance program for the poor that cost only 1 PEN. He told me about it in passing, which made it seem like it was an arrangement his clinic in particular had

come to, suggesting that he did not seem to allot it much importance, and I did not enquire further. The CLAS workers in Clinic B did not mention it to me, and only once I got home and looked through my photographs of the posters that lined the walls of the Clinic B did I notice a poster for the SIS<sup>35</sup>. This suggests that although I made it clear to the doctors and health care workers that I was interested in investigating specifically how poor *campesinos* negotiated health care in their clinics, no one felt impelled to draw my attention to the insurance that is specifically directed towards the poor. Furthermore, none of the Añawayans that I interviewed mentioned this insurance plan to me, and their frequent complaints about the cost of laboratory analysis and medicines imply that they did not know about the SIS. Many rural villages that are beset by poverty surround the town where the clinic is located. The provision of economical or free health care could potentially jeopardize the financial well being of the clinic, which could explain why the insurance program is so poorly publicized.

Indeed, due to the inability of many rural poor to pay the user fees, many of the CLAS in marginal areas are not fairing well financially and furthermore receive no emergency financial backing from the Ministry of Health (Iwami & Petchey 2002). To illustrate, Altobelli (2002) offers an example of a CLAS clinic in a poor area in the outskirts of Lima that attempted to solve its financial problems by increasing consultation fees and significantly reducing (by 63%) their non-income generating programs. Non-income

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<sup>35</sup> This poster differed from many of the other cartoon like posters advertising vaccination campaigns and breastfeeding. Printed on the poster is a great deal of Spanish text that may be difficult for Quechua speakers to follow. On the bottom of the poster, there is a note that the SIS assures free health care for those who are in extreme poverty. In addition, there are phone numbers to call (it seems that one cannot purchase it from the clinic). The closest number to call is Cusco – and there is a toll free number. In the village, there was one privately owned phone for the entire village, so people were neither very accustomed to the telephone, nor did they have easy access to it. Furthermore, the provision of a telephone number as the only source of information of this insurance suggests that the planners of this program do not take into account the possible repudiation the campesinos may feel calling an office in the city, with little or no experience with telephones.

generating programs are often those that focus on issues that affect quality of life<sup>36</sup> (Altobelli 2002), identified by the Alma Ata declaration as being important to the overall health of populations. Increasing user fees and cutting programs may be necessary to keep the clinic in business, but in effect undermine the original mandate of the CLAS of providing low cost health care to the poor, tailored to local needs. Since the CLAS relies on its revenues to keep the clinic in business, there must be a population that is able to assume those costs and generate income for the CLAS to survive. It follows then that these problems are exacerbated in rural areas, where poverty is just as, or more rampant than in suburban areas (Altobelli 2002). Interestingly, 69% of all CLAS are located in rural areas (Cortez 2000).

When asked if they thought a CLAS clinic is sustainable in either a rural and /or poor neighbourhood, the CLAS workers I interviewed unanimously responded that it would not be possible. One doctor claimed:

In small villages, I don't think it [CLAS] would work. Because no matter what, the CLAS will always do its...will always have its price, and every service that we offer must always be paid for. Why? Because with these resources that we take in, we purchase our equipment; we pay the personnel<sup>37</sup>; we purchase logistical materials for the maintenance of the establishment<sup>38</sup> (Interview 201).

Another health worker told me that the first clinic in the Cusco region to become a CLAS was in a relatively wealthy, urban neighbourhood (Interview 205). The clinic succeeded, because with its profits, specialists were hired and newer technology was purchased, which made it that much more attractive. Its urban location made it possible for people of diverse

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<sup>36</sup> Such issues may be alcoholism in rural communities, stress management, or spousal abuse.

<sup>37</sup> The doctor is referring to personnel other than doctors, nurses and technicians who are paid by the Ministry of Health.

<sup>38</sup> *En los pueblos chiquitos, no creo que funcione. Porque de todos maneras el centro de salud que es CLAS siempre va hacer su – va tener siempre su tarifa, y cada servicio que se hace siempre es pagado. Porque? Porque con estos recursos que se capta se hace el equipamiento, se paga el personal, se compra materiales logísticas, par el mantenimiento del establecimiento*

economic status to access it. Profits gained from this economically diverse cohort are used to cover user fees for those who cannot afford treatment. Over and over the CLAS workers I interviewed impressed upon me the infeasibility of a CLAS clinic ever sustaining itself financially in areas of more homogenous low income. In 2000, 22% of the CLAS were located in zones of the lowest income quintile and 40% in the second lowest quintile (Cortez 2000), suggesting that many of them could be facing financial difficulties, and calling into question the long term sustainability of the program.

In my study, both clinics expressed that they lacked funds for necessary items or supplies. Clinic A is located at the edge of a world-class tourist site. As a result, they not only serve their surrounding 17 villages, but also all the workers and tourists that regularly flow through the town square. Clinic A is currently crammed into the top floor of the municipal office, a small building made out of adobe and concrete. Its total area is approximately 350 m<sup>2</sup>. While the CLAS committee has purchased the land on which to build a new clinic, they cannot afford to construct the building and lack governmental support to do so. Even though the government maintains in its *Decreto Supremo* (MINSA 1994) that they provide adequate infrastructure for CLAS clinics, they have withheld this from Clinic A. The clinic has attempted to apply for government grants (the nature of these grants were not specified by the informant (Interview 203)), but have narrowly missed their deadlines. Perú is highly bureaucratized and navigating the demands for papers and forms is well known to anyone who has spent any length of time in this country. In this instance, once the CLAS had submitted their funding application, they were continually told they must apply for various forms and information from other government bureaus. Consequently, the deadline for the application was missed.



The cramped conditions of the Clinic A provide little privacy. In fact there were no separate rooms in this clinic, and 'cubicles' were separated with nothing more than low partitions, with no door or curtain to close them completely. One day I was helping out by folding gauze strips in one of the cubicles while several campesino women were asked to expose their buttocks for injections. It follows that although the CLAS workers try to persuade the campesinos to come to Clinic A, they are uncomfortable not only with the strange surroundings, but as an elected CLAS member put it, they want their privacy just as much as any other person. As for any other type of business, this situation is a vicious circle for the Clinic A; the less people want to go, the less profit they have, and consequently the less money they raise to build a new clinic. In another example, Clinic B has vehicles that are meant to facilitate their access to the rural villages, as well as serve as ambulances when needed. However, often they cannot afford the fuel to run them. Consequently they have had to set up a credit system with the local fuel station.

#### **4.2.1.3 Decentralization**

This section proposes to characterize the decentralization of the CLAS, through the use of two examples of how administrative decentralization is achieved. I will examine the CLAS policy of community participation as well as the communication of health programs and promotions that take into account the needs of local peoples, but which are in fact designed centrally.

Decentralizing health services is a popular approach to health care reform (Arredondo & Parada 2001) and the CLAS is no exception to this. The concept of decentralization is very complex and often understood to be different approaches by different people (Brohman 1996). For example, it may be understood as bestowing more

power onto local communities, but it can also take the responsibility of various sectors away from the government so that they are more able to pay their external debts. It is also important to consider that centralization is commonly pitted against decentralization (Samoff 1990) as a dualism when it is more accurate to say that countries embrace varying degrees of both centralization and decentralization. While there are various flavours of decentralization, there appear to be two main perspectives: administrative decentralization and political decentralization (Samoff 1990). Political decentralization is characterized by the focus on the empowerment of populations who are marginalized, and on shifting the power to make decisions to said groups (Samoff 1990). On the other hand, administrative decentralization is characterized by a focus on efficiency of services, and institutional decentralization.

The CLAS' approach to decentralization is a hybrid of political and administrative decentralization. The CLAS has a policy of local empowerment through community participation, yet describes itself as *administratively* decentralized. Important decisions such as the nature of health promotional programs and the organization of the CLAS system are made centrally either in Lima or in the regional health offices, while the community and the power of the clinic is limited to fiscal control as well as administrative duties. It is often the case that administrative decentralization is implemented in order to increase efficiency of services at the expense of empowerment (Samoff 1990). In fact, decentralization of this nature is better understood as a "façade for maintaining or reinforcing central authority", thereby "reinforcing power relations" (Samoff 1990, 517).

#### 4.2.1.4 Community participation

The creation of community-controlled health care was thought to increase social participation. In light of the gross overspending of governments during the 1970s and 1980s, it was thought that the control and surveillance by communities would increase fiscal responsibility and control of resources (Altobelli 2000, Cortez 2000, Noel 2005).

Community participation is common to political decentralization and is thought to empower local peoples (Altobelli 2000, Arredondo 2003). By creating a health structure that includes the participation of community members the CLAS system is potentially able to break from centralized control of the management of health services (Cortez 2000) and move towards a more locally appropriate approach. Accordingly, the CLAS system is reported to be built on a tradition of grassroots organizing and is often promoted as a 'ground up' response to the demands of grassroots organizations that have a history in Perú (Iwami & Petchey 2002)<sup>39</sup>. Indeed, the elected community participants of the CLAS are entitled to, and have the responsibility to make decisions not only about functional duties<sup>40</sup>, but also about health programs and promotions.

Additionally, there is a tremendous opportunity for elected members to bridge differing ideologies of biomedicine and traditional medicine. One elected community participant for Clinic A was a *mestiza*<sup>41</sup> who was also the governor of the town (Interview 203). She had a great deal of respect for local beliefs, and although she claimed to be largely ignorant of the local knowledge, her comments revealed that she was more informed, perhaps intuitively, about the local people and their ways than she may have been aware.

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<sup>39</sup>It is important to note, however, that this contrasts sharply with Cortez's (2000) account that CLAS is a government initiative, which will be addressed in more depth below.

<sup>40</sup> By functional duties, I am referring to small details, such as how to spend their profits, who to hire as specialists, how to allocate funds for various overhead items.

<sup>41</sup> *Mestizo* (mixed) usually refers to a person of indigenous ancestry on either side of their family that speaks Spanish and participates in the market economy (Price 2003)

She appeared to be intimately involved with the clinic, and I saw her on several occasions in the clinic chatting with health workers about various issues. In one case there was a woman in a remote village that was in danger of having complications during her childbirth, but did not want to come to the clinic to give birth. Very patiently the elected community member explained to a CLAS worker why the woman may be frightened to come to the clinic, and that perhaps, as is common with many rural indigenous women in this area, she did not want to leave her other children at home. Together they were discussing a solution to this problem, based on the elected community member's cultural understanding of the woman in question. This incident effectively demonstrates the potential of elected community member to bridge differing ideologies. This 'bridging' can help the clinics in their attempt to enhance their cultural sensitivity.

In spite of its potential, community participation has many different manifestations, and it is important to look beyond the rhetoric. Indeed, the model of community participation adopted by the CLAS system is discussed as a shortcoming (Altobelli 2002). In the 1960s when community participation was introduced in the health sector, one of the main reasons that it failed to make any lasting changes was because it was often implemented through top-down initiatives legislated by governments (Altobelli 2002). In fact, in a Peruvian context, before the establishment of the CLAS, 'community participation' referred to the mobilization of the population for vaccination campaigns, a decidedly 'vertical' (state created) type of community participation (Bowyer 2004). To illustrate further, in the past the World Bank promoted the implementation of user fees (also used in the CLAS system) as a form of community participation (Altobelli 2002), when really it is a reform that serves to render health care inaccessible to many. Indeed, there are many different ideas about

what community participation constitutes (Wayland 2002) and it is important to contextualize this discussion to understand its complexities.

Originally in Perú, the government did not perceive the need to include local participation in government-established health systems, as communities continued to rely on local medical systems including traditional healers, local knowledge, traditional birth attendants and bonesetters (Bowyer 2004). Consequently, when PHC was introduced on the healthscape, vertically appointed committees replaced many traditional social networks that were already in place (Altobelli 2002). Traditional values were considered an impediment to the improvement of the health of the poor, and the poor were perceived to be unable to organize themselves (Ugalde 1985). Additionally, many of the tools used to educate communities about health did not operate from an understanding of cultural context and limited the interchange of ideas between locals and the state (Altobelli 2002). Having achieved some improvements, the CLAS unfortunately appears to commit some of the same mistakes of the 1960s that led to the failure of community participation. Having finally included community participation in the primary health system, the appropriateness of the participation must be questioned.

As previously mentioned, the community participates in CLAS by sharing the administrative tasks of running the clinic. This may include the allocation of resources; accounting; the purchase of materials and supplies; and communication (Cortez 2000). If financial circumstances permit, it also includes input regarding the hiring of specialists, which could potentially attract more patients<sup>42</sup>. A significant barrier to the execution of these duties, however, is that many members of the community lack the training and education

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<sup>42</sup> The hiring of specialists such as dentists of course is only possible in CLAS clinics that are making profits, which are usually urban clinics. Rural CLAS clinics struggle to sustain themselves financially and are less likely to be able to afford a specialist for their clinic. In Clinic B, they had recently hired a dentist.

needed to conduct administrative duties such as book keeping or the administration of human and financial resources (Iwami & Petchey 2002), which is further compounded by a lack of logistical support and guidance from MINSA in regards to administrative duties (Cortez 2000). In fact, according to all the health workers and the CLAS bureaucrat in Lima interviewed, the most significant barrier in the CLAS system is the low level of participation from the community members. Considering that the rate and quality of the community participation depends on each individual community and its capacities (Altobelli 2002), it is easy to deduce that community participation in many of the communities is severely compromised. Additionally, CLAS clinics are required to act within the guidelines decided on by the state and are held to this obligation by virtue of the fact that each CLAS clinic depends on the state for three-year contracts (Iwami & Petchey 2002). It is important to note, however, that the state can cancel the contract with the community at any time if the obligations are not being carried out (MINSA 1994) but there is no possibility for the community to cancel the contract with the state if they wish to do so. In effect, this suggests that the government, and not the community, retains control over their clinics.

Consequently, disenchantment abounds on the side of the community but also on the side of health workers. One doctor I interviewed regretted there was no one at his administrative and medical level to verify his actions and help him avoid mistakes. This was significant in his case since he, like many CLAS doctors, was often fatigued and

overworked<sup>43</sup> due to the fact that he had to perform administrative duties that community members were unable to complete. Consequently, the extra time spent on each action to ensure the absence of error, exacerbated his exhaustion. In urban CLAS clinics, this is less pronounced as the elected community members are often more educated than their rural counterparts, and are better prepared to assist in administrative duties. In rural areas, however, the lack of education prevents many community members from participating in the way the state desires them to, causing frustration on either side. Moreover, relationships between local health clinics and rural people are already strained. Such strains are due to various discords of the recent past between health clinics and locals such as, but not limited to: Peru's forced sterilization of indigenous women (Coe 2004); as well as accounts of threats from local doctors that legal problems would result if locals refrained from bringing their sick to the clinics. The image fostered through the CLAS initiative that the State cares about the health of its citizens is being undermined due to both the narrow scope of its community participation (Bowyer 2004), and past breaches of trust that are still alive in people's memories that reveal that local empowerment is not being achieved. In fact, as is characteristic of administrative decentralization, power relations from the past are reinforced and continue to colour current interactions between the clinic and locals.

To illustrate, it has been reported that very few people (20%) are aware that community members are elected (Iwami & Petchey 2002) and that the CLAS is jointly administered by the state and community (Bowyer 2004). Additionally, Bowyer (2004)

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<sup>43</sup> The CLAS system has recently increased its demands on doctors. While they are obligated to work a minimum number of hours, there is no maximum number of hours they can work. In fact, my observations suggest that the health workers were even encouraged to work as many hours as it took to make their clinic (financially) successful. A common benefit of a clinic being administered by CLAS, according to many of the health workers, was that there was someone on staff 24 hours a day. In Clinic B this meant that the head doctor often slept at the clinic after working a 10 hour shift, and other health workers would fill in (once again after working their regularly scheduled shifts) when he was unable to stay.

reported that in regions that CLAS clinics cover, 95% of the locals did not participate in electing community member and 91% did not know who the elected members were. My research corroborates these findings. The villagers I interviewed did not recognize a difference between a state-sponsored clinic and a CLAS clinic, and did not know how or when to vote for community participants. The doctors I interviewed agreed that most people in the community were unaware that community participants were elected. It has also been reported that in some communities all the community participants were appointed rather than elected (Altobelli 2002). In my sample, several CLAS workers indicated that often the elected members were merely appointed. Other times they are local elites, reifying power relations. In a similar manner, although community participants are often people from the town where the CLAS is located, some of the community participants actually live outside the area, and often did not attend the obligatory monthly meetings. One doctor suggested that many elected members enjoy the prestige that comes with this position, but are not interested in the enhancement of the clinic (Interview 210). While I was in Clinic B, the elected members were never present, and the doctors were unwilling to put me in contact with them, claiming that their only participation was during the monthly two-hour meeting where the health workers report to the community members. I suspected that they did not live in the village. In addition to the local people being unaware, even many of the elected CLAS members are not fully knowledgeable of the institutional structure and processes of the CLAS and as such have very limited social control and authority over policies and programs (Altobelli 2002). The lack of meaningful participation led one doctor in Clinic B to refer to community participants as playing an 'honorary role' in the clinic. This puts into question CLAS claims of grassroots organizing and empowering local community members.



Although community participation is presented as a high priority objective of CLAS, it is actually subordinate to (fiscal) efficiency (Cortez 2000, Iwami & Petchey 2002). This local scale study reveals that sacrificing meaningful community participation for the benefit of fiscal efficiency comes at an expense, however, especially to the doctors and eventually to their patients. With the CLAS acting as a *de facto* business, the government appears to take advantage of doctors' commitment and sense of responsibility. Doctors reported that the competition for a paid position (doctor, nurse or medical technician) in the CLAS clinic is very high, and the community evaluates health workers every three months. Accordingly, the doctors do everything in their power to keep their appointments even if it means lack of sleep, which is not only unpleasant but can also compromise their skills. In both clinics, the managing doctors (*gerentes*) were overworked and visibly fatigued for all the extra work and time put into the clinic. They demonstrated a strong commitment to bettering the clinic, and largely took over administrative duties the elected members were not capable of. To illustrate the extent of this commitment, the *gerente* of Clinic B (Interview 210) works approximately 700 km (or an 18 hour bus ride through the Andes) away from his hometown where his wife and children reside. He visits them once a month, and spends most of his nights sleeping on a cot in the hospital so there is always someone at the clinic in case of emergency. In such a state, it is debatable whether doctors can perform at their best. While community participation could potentially alleviate the situation, the current CLAS model of administrative participation does not foster that. Moreover, Cortez's (2000) claim that community participation in the CLAS can at best be characterized as "active but dependent" is supported by this research. Indeed, in my samples it is debatable as to how active the community was at all. In Clinic A, the aforementioned participant was very active, but it did not appear that the other members were. In Clinic B, the head doctor referred to his three

'elected' members as occupying no more than an honorary role in the clinic, as their activities consisted of nothing more than attending a two-hour monthly meeting.

The above arguments illustrate some inadequacies of community participation in the CLAS initiative. Rather than being part of the process of improving the health sector, the type of community participation embodied in the CLAS acts as a means to an end by offering the government a way to fulfill one of the pillars of PHC (Altobelli 2002). The suggestion that the CLAS system often pays lip service to community participation (Iwami & Petchey 2002) is corroborated in this research project, with the important exception of one elected member I was able to interview (Interview 203). While this participant was extraordinary in her commitment to the clinic, for my sample she was the exception rather than the norm. Furthermore, the question remains as to whether her participation can be categorized as stemming from 'grassroots' and 'local', given that she is the governing official of the town. It is no question that she was an asset to Clinic A, but her position of power over the local indigenous people makes it debatable as to whether her membership can be characterized as community participation, or instrumental in maintaining her role in the village elite.

#### **4.2.1.5 Health programs / promotions**

It has been suggested that reports of high user satisfaction are in part due to programs that have incorporated health care needs that are identified by local communities (Cortez 2000). Indeed some campaigns have helped persuade *campesinos* to go to the clinic or hospital at the onset of certain symptoms. In the CLAS clinics, for example, a series of posters are issued by the government to control respiratory problems, which are the most common causes of morbidity in the Andes region due to the cold, high altitude, and smoke

inhalation due to the combustion of solid fuels inside the home. I was told that their effectiveness is due in large part to an understanding of how indigenous people of the Andes conceptualize illness. Rather than focusing on the pathogenesis of disease, typical of biomedicine, Andean nosology<sup>44</sup> focuses on symptoms, and as such, the CLAS focuses its campaigns on the symptoms. For example, several posters on the walls of both clinics highlighted the symptoms of pneumonia, with the text: “If your child has rapid or agitated breathing, bring them immediately to the health clinic.” The indigenous parent recognizes ‘rapid and agitated breath’ much more quickly than ‘pneumonia’. Another program that has had some success, and that will be addressed later in this discussion, is maternal care. As previously mentioned, the CLAS has tailored its maternal program to allow for traditional birthing methods to be practiced in the clinic, thereby increasing the number of women giving birth in clinics as opposed to in their homes in rural villages. While these programs and campaigns have had some success in persuading locals to visit the clinics, it is important to examine how local needs have been incorporated and assessed.

The claim that the CLAS incorporates local needs into its programs implies that programs and campaigns are designed locally and tailored specifically to the community in which they are located. However, most programs and campaigns that are actually implemented through the CLAS are created nationally (vertically); some programs do not necessarily respond to the identified needs; and similarly it is unknown how the community’s needs are determined (Cortez 2000). In rural areas this is particularly important due to their unique health issues. Here I refer to health problems that may be endemic to specific areas and exacerbated by altitude and poverty; and the fact that most rural regions in Perú are demographically the indigenous, poor, subsistence farmers that have beliefs about health and

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<sup>44</sup> Nosology is the branch of medicine that deals with the classification of disease.

healing that differ from a biomedical framework. Moreover, as it has been discussed, local participation in decision-making is reduced in rural areas (Cortez 2000), exacerbating the situation. This is especially pertinent given that the CLAS' mandated priority is servicing the poor and rural. It is therefore questionable whether centrally designed health programs are the best solution to rural health issues. While one of the responsibilities of the elected members of the CLAS is to design programs that are based on local needs (Iwami & Petchey 2002), the previous discussion indicated that elected members usually play only honorary roles in the CLAS clinic. There is further evidence that indicates that CLAS clinics are not in a good position to create programs. By trying to stay afloat financially, their human resources are often exhausted. As indicated earlier, some clinics were forced to decrease their non-income generating programs in order to survive financially.

During my research, I was not able to witness the implementation of programs with great depth due to time restraints. However, I observed the health promotional posters that lined the walls of the clinics, talked to some health workers about their programs, and assisted during a day of maternal and infant monitoring – a selective PHC initiative designed to focus particularly on maternal and infant wellbeing. Many of the campaign posters in the clinics are illustrated in cartoon form, and are bright and colourful, depicting indigenous families with happy smiles on their faces. For example, the previously mentioned poster addressing the symptoms of pneumonia depicts a nuclear *campesino* family of four (See Figure 4.1). The full caption on the poster reads “Change Pneumonia for a smile! – If your child experiences rapid or agitated breathing, take him immediately to the clinic<sup>45</sup>.” While a toddler embraces the leg of his smiling father, the mother happily breast-feeds an infant. The family is dressed in traditional wear of bright ponchos, and *ch'ullus* (woven caps with ear

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<sup>45</sup> *Cambia la neumonía por una sonrisa. Si tu niño tiene respiración rápida o agitada, llévalo de inmediato al puesto de salud.*

flaps) that are typically woven by the mother. There is a fluffy white lamb in the foreground, amidst a backdrop of blue skies, green mountains, flowers, newly ploughed fields and a cute, white, cottage type house that looks nothing like the adobe structures that sprinkle the true countryside.



*Author's photo*

*Figure 4.1: Pneumonia poster in Clinic B*

While the Andean people have considerable capacity for laughter and humour despite their difficult lives, the poster displays an idealized bucolic Andean countryside. Although the village where I conducted my research may not be representative of every case in the countryside, it was nonetheless very different from this poster. One is more likely to see a family (sometimes extended – including grandparents) of at least four children, sometimes up to eight or nine, dressed in ill-fitting western clothing that often bears the evidence of hard work on a farm. The mother does not have a big smile on her face while she is breast-feeding her latest child that she probably did not plan on having. The lines on her face and visible fatigue betray the difficult life she leads. The husband is probably in the fields, ploughing them with an ox and wooden plough, and in many rural villages, alcoholism runs rampant among both males and females. The poster depicts a clean and sterile countryside, but in fact the countryside, like farms and rural areas everywhere else in the world are messy. An Andean patient that comes to the clinic to be treated most likely just came from work on the farm, and he or she may not be as clean and sterile as the posters depict. The posters portray a pure, sterile and ‘cute’ profile of the Andes and the Andean people. Perhaps it reflects a desire on behalf of the professionalized urbanites to ‘clean up’ the countryside, and render it more sanitary, cleaner, and more civil.

While waiting to interview one of the doctors one day, I came across a set of canvas posters that were high up on a shelf collecting dust (see Figure 4.2). The posters were beautifully drawn cartoons on the topic of stress. While it is undeniable that the villagers and locals may experience stress and could benefit from learning about it, the posters did not look like they were being used, or had not been used for a very long time, as they were dusty, wrinkled and ink stained. This may suggest that even though the campaigns may be well researched and appropriate, they are not necessarily being communicated to the locals.

Furthermore, while the posters acknowledge that many people feel stress because of poverty and related factors, the appropriateness of the solutions the posters suggest is questionable. It is suggested that a systematic evaluation of the stress factors be conducted, on one's own or with a workshop group. It is unlikely that those who are suffering from stress because of poverty, such as my informants in the village, would have the time to devote to a workshop due to the amount of work necessary when earning a livelihood through subsistence agriculture.



*Author's photo*

Figure 4.2: Stress prevention poster in Clinic B

Another poster campaign was for the promotion of breast-feeding (see Figure 4.3). On a large placard in the waiting room, the benefits of breast-feeding were listed in little cartoon bubbles. The poster consisted of cut outs of photographs and text as well as text boxes. The viewer was informed of the benefits of breast-feeding, that it makes children grow healthy, strong and intelligent; it is cheaper than buying milk; clean; and ready at any given moment, day or night – no preparation needed! There is also a picture of a baby bottle and soother with a red felt cross through it, and the heading “¿Biberon? ¡¡NO!!” (Baby bottle? NO!!) It also informs that breast-feeding protects the infant from illness, prevents breast cancer, and fosters the infant-mother union, giving the child a feeling of security and confidence. There is also a white board where the explicit instructions for how to breastfeed are written down, next to another hand drawn picture of the same baby bottle and soother, with the same heading drawn on a poster sized piece of paper – the message could hardly be missed.



Author's photo

Figure 4.3: Breast feeding promotion poster in Clinic B



The current and necessary widespread promotion of breast-feeding is ironic considering the baby formula push during the 1960s and 1970s. PHC clinics unfortunately have had to contend with the consequences of baby formula on the market, despite the WHO's international code against marketing baby formulas promulgated in 1981. In spite of this code, baby formula has been associated with modernization, and as such, sometimes preferred over breastfeeding. A full examination of issues surrounding baby formula is beyond the scope of this discussion. However, it is interesting to note the way that the benefits of breastfeeding are communicated in the clinic, especially since the clinic and baby formula companies are both aspects of modernity in the eyes of rural indigenous populations. The mixed messages do nothing to nurture trust. That said, it is ironic that there is a necessity to urge and teach mothers to breastfeed, when they have known this all along, and when it was international companies that pushed them to give up breastfeeding. With its somewhat authoritarian and infantile pedagogy, the posters seem to suggest that it is the ignorance of the indigenous people that has led them to use formula rather than breastfeed.

As part of the selective approach to PHC, the clinics I visited also conduct an infant monitoring program. This program, like many of the selective approaches, is easy to monitor and results are uncomplicated to report. Expecting mothers are monitored throughout their pregnancy and must give birth in the clinic instead of in the country at home. They must bring in their children once a month to be monitored for weight, height and a series of developmental skills, for the first year of their life. I arranged with one of the doctors to come in on the day that they conducted the infant monitoring to lend a hand. He gladly accepted, telling me that it was a very busy day, and they could use the help. When I arrived at the prearranged time, I sat in a cubicle, and waited for a long time before I was

addressed by any of the health workers. They sat for this time and talked and joked amongst themselves – the only time I saw them relax at all. Finally, I was led to a small, cold office with not much more than a baby scale and a chair and desk in it. The health worker was just finishing with one couple and their small infant. He spoke only to the father of the family, asking him very intimate questions about the well being of his wife, including such intimate details as when her last menstruation was. The health care worker made no eye contact with the mother while asking these questions. I learned later that it was most likely out of respect for the husband that the male health care worker did not address his wife. It made me wonder, however, why a female health care worker was not conducting this exam, when there were plenty of female health care workers in the clinic.

When he was finished he told me I could carry on conducting the next examinations. I told him I was not trained and that he would have to show me everything. He told me I would have no problem, and that everything was written on the sheet where I had to fill in the information. Even though I told him I would feel more comfortable watching him conduct at least one examination, he reiterated that I would have no problem that I just had to read the instructions, and quickly walked out of the room. He said he would be back in an hour, but did not return for almost two hours. Not being trained in child development (which he was aware) I of course had no idea how to conduct the myriad tests that were supposed to indicate the wellness (mental and physical) of the child. However, regardless of the fact that this was an isolated incident within my research, the manner in which the health worker treated this incident implies that he was not bothered by inaccurate results. This is significant when considering that this program is important for statistics and informs policy.

In contrast to the posters in the waiting room, a doctor in Clinic B had a small, framed painting in his office that caught my attention. It pictured five indigenous men from

another time, implied by the ancient ceramics that surround them, their dress of traditionally decorated loincloths, and carved stone arrowheads being used to perform what appears to be head surgery on the man lying down. One man holds the ‘patient’ down, another looks on, and a man with a staff and decorated cape looks on. In contrast to the majority of the posters in this clinic, this vision of the indigenous people is solemn and the *indigenous* man is in charge of the surgery. This departs radically from the childish cartoon like depiction of the posters in the waiting room for the benefit of the locals, depicting the happy, sterile *campesino* family. The contrast of these pictures reflects the current views held by those in positions of power of *campesinos* in Perú. While the ancient civilizations of Perú are deeply respected, the current view of *campesinos* in Perú ranges from one of ‘folkloric simplicity’ in which the indigenous are regarded as ‘cute’ and traditional, to one of blatant racism, and lack of those views are the exception. I witnessed this racism on a regular basis during my travels<sup>46</sup>. While I make no claims that the pattern of these posters depicts the *modus operandi* of the CLAS clinics, they do send a message. Such posters, I argue, reflect power relations in the clinic and reflect the underlying feeling among the Peruvian elite that the ‘time of greatness’ of the indigenous cultures is over, and the indigenous people today must be treated gently like children. This attitude serves to justify the position of power held by the clinic, and contributes to the lack of meaningful community participation.

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<sup>46</sup> To illustrate, one of my key informants belonged to a country club on the beach in Lima. The members were exclusively white, and my companion joked about *cholos* (derogatory term for half-breed, or mixed race) not being allowed in – only to work. One wealthy woman in Lima informed me that all of Lima’s problems were due to the people of the *provincias* (territories outside the capital) invading Lima and setting up their shantytowns. I also witnessed frequent verbal abuses directed towards *ambulantes* (people selling small wares, such as gum, roles of toilette paper, copies of ancient ceramics, in the streets. They approach vehicles while they are stopped at red lights). I also heard many comments that implied a ‘fall from greatness’ of the indigenous people, that they are untrustworthy, and that they lie and steal.

### 4.3 Conclusion

These observations lead me to question whether CLAS fulfills the criteria of comprehensive PHC, and whether it is the most viable and appropriate model of PHC for Perú. The CLAS initiative appears to function in areas where there is some degree of financial stability among the residents but not in poor areas, even though CLAS is touted as a solution to health care for the poor (see Cortez 2000, Government of Perú 2000). Also, while there is a discourse of decentralization and local empowerment, the government still exerts a great deal of power over the functioning of the CLAS. The model of decentralization that the CLAS embodies eases the government of the burden of administering the health centres, while maintaining a significant amount of control. In the decentralization processes the internal politics between central and regional authorities seem to obfuscate the real needs of health care users (Iwami & Petchey 2002). A factor in solving this dilemma could be community participation; however, the CLAS program only pays lip service to community participation, especially in the poor and rural areas. This is unfortunate since community participation not only offers an opportunity for local needs and cultural context to be addressed, but it also cultivates democratic processes that are seen as a necessary part of creating sustainable development in poor countries and leads to local empowerment (Altobelli 2002). Also, from a purely utilitarian framework, community participation can reduce costs by relying on donated local labour (Altobelli 2002). If the CLAS has become even more inaccessible to poor and rural populations, how do people negotiate health care treatments?

## Chapter 5: Añawi Village and the use of Medicinal Plants

### 5.1 Introduction: the integration of traditional medicine in PHC

The biomedical and modernist perspective assumed that traditional medical systems would eventually die out with the implementation of the technologically superior biomedicine. The recognition in the 1960s and 1970s that ‘traditional medical systems’ were thriving rather than disappearing led to policy recommendations that they be integrated into biomedicine and specifically PHC clinics. Accordingly, international health initiatives took a renewed interest in traditional medicine, which was considered both cost effective and accessible, in order to integrate it into biomedicine (WHO 2002). Furthermore, an understanding of the cultural aspects of traditional medicine was seen to be important in the delivery of biomedical health services (Miles & Leatherman 2003). Nigenda *et al.* (2004) argue that through integration of traditional medicine into biomedicine, financial barriers would decrease, thereby increasing their use. They argue that by instituting and formalizing traditional medicine, this would potentially save traditional medical practices from the threat of globalization. International health initiatives, such as “WHO Traditional Medicine Strategy 2002 – 2005” (WHO 2002) continue to focus on the integration of traditional medicine into PHC initiatives.

However, experiences with PHC systems have led many to argue that integration of traditional medicine is neither viable nor a realistic portrayal of the healthscape in many areas (Wayland 2004, Janes 1999). The focus on integration tends to understand traditional

medical systems and those that use them as static, bounded entities, all the while neglecting processes and actions that permeated these 'false boundaries' such as the fact that people rely more on various medical techniques, rather than one single system of medicine (Miles & Leatherman 2003). Accordingly it is noted that indiscriminate integration of indigenous medicines into biomedicine faces a number of "conceptual and political barriers" (Janes 1999, 1804). Since medical systems reflect the cultures in which they are practiced, it is hardly surprising that the integration of one medical system into another would be problematic. When it comes to health, knowledge is a very powerful tool. Those that hold knowledge of how to deal with ill health hold powerful positions. Many governments in developing countries have put in place biomedical systems not only because of their therapeutic worth, but also in the name of capitalism, development and social advancement (Baer 2003, Conner 2001). With the "structural and cultural dominance" (Janes 1999, 1804) of biomedicine, the integration of indigenous medical systems into biomedicine can render them,

so much like biomedicine, so rationalized and 'sanitized' of their alternative epistemological tenets that they may not be able to meet the human and social needs of the rapidly approaching health crises produced by structural adjustment and the epidemiological and demographic transition (Janes 1999, 1805).

This suggests that indigenous medical systems play an important role in their capacity to offer something that is beneficial to the health of those who seek it that they do not receive through the biomedical system.

Integration then can lead to undesirable situations, such as loss of identity of the traditional medical system once integrated into biomedical systems, or the submission of indigenous medicine to western medical systems (Janes 1999). The attempt to integrate traditional medicine and PHC may result in the suppression and subordination of traditional

medicine under biomedicine (Baer 2003, Hyma & Ramesh 1994), or the *biomedicalisation* of traditional medicine<sup>47</sup>. Additionally, because medical systems are embedded in cultural systems, loss of cultural identity can render the medical system either inappropriate or ineffective. Accordingly, Janes (1999, 1805) argues, “indigenous medicines offer not just medicines, which are but materialist props, but alternative definitions of experience that link suffering to wider social and cultural phenomena.”

The limitations of integration are reported elsewhere. Del Casino (2004) discusses the results of the integration of Thai medicine into the biomedical system. Thai medicine practised within the clinic was ‘modernized’ superficially by giving the preparation of herbal remedies an air of “sterility and scientific precision” (p. 68), while preparation of the same herbs outside the hospital remained somewhat unsanitary. As well, Barrett (1995) demonstrates how in Nicaragua the practices of traditional healers can become medicalised and subverted through the act of integration. The Sandinista government in Nicaragua promoted the integration of traditional medical practitioners by training them biomedically. As a result, only traditional practitioners that had obtained the certificate were legally allowed to practice. Despite good intentions, this served to undermine the authority of other practitioners that had not been trained. Similarly, in Nepal, the training program for traditional birth attendants is seen as prestigious, being the reflection of modernisation, and thus sometimes socially elite local women with no previous experience or interest in midwifery are the ones trained rather than the local birth attendants (Pigg 1995). These examples illustrate the assimilationist ideology behind the notion of integration, and the

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<sup>47</sup> Biomedicalisation is described by Waldram (2000, 609) as “involving the incorporation and use of biomedical language and technology by traditional medical practitioners” and includes the idea that traditional medical practitioners, “may speak of “diseases” and “cures” in biomedical terms, but without comparable biomedical understanding.”

“structural and cultural dominance” (Janes 1999, 1804) that biomedicine holds over indigenous medicine.

Accordingly, most scholars analyzing the interactions between biomedicine and traditional medicine have rejected the integrative approach and instead focus on a model of medical pluralism to describe the interrelationships between biomedicine and traditional medicine (Janes 1999). Proponents of this model propose that persons seeking health care rely on a variety of medical systems, including indigenous medicine regardless of the presumed authority of biomedicine. Researchers suggest further that medical systems are not static, but syncretic and dynamic, coexist with other medical systems, and that biomedicine is just one of several different systems that are accessed by people (Casteñeda *et al.* 2003, Hyma & Ramesh 1994, Izugbara *et al.* 2005, Madge 1998, Pedersen & Baruffati 1985; also see Koss-Chioino *et al.* 2003 and references therein). More specifically, Pedersen & Baruffati (1985) describe Latin America as having a:

[m]osaic of intermediate models, a consequence of the historical relations between Indo-American medical cultures and the medical cultures of other continents, resulting in complex medical systems which are an organizational response to the cultural forms of medicine continuously recreated by society in its struggle against disease and its permanent quest for health (p. 6).

Accordingly, while indigenous medical systems and biomedicine have typically been described as a dualism with one being superior over the other, the relationship is more appropriately described as a duality in which the boundaries between the two systems are blurred, and they become “both and at the same time complementary and competing” (Ngokwey 1995, 1143). In fact, Stoner (1986) suggests that the point of departure for research in medical pluralism should be the multitude of medical techniques, with “less emphasis on the particular ‘system’ from which they derive and in which they operate” (p. 47). It follows that while people practice indigenous medicine, the parallel use of



biomedicine does not necessarily change people's beliefs about health and illness. Rather it merely indicates they seek a solution for their health needs, not a change in ideology (Madge 1998). Medical pluralism can be a useful model for this research, and what follows is a brief summary of the main ideas of the literature that surrounds medical pluralism in the Andes.

## 5.2 Medical pluralism in the Andes

Inspired by Crandon-Malamud's (1991) ethnography *From the Fat of our Souls*, which looked at medical pluralism in a small village in the Altiplano of Bolivia, medical anthropologists have produced a rich collection of studies concerning the health and health systems in the Andes. The dominant theoretical approach to health in the 1980s was that indigenous medicine should be integrated into biomedicine, and indigenous medicine was theorized within a biomedical framework rather than through the worldview of the culture from which it came. Crandon-Malamud (1991) revolutionized the existing theoretical framework by examining how "social identity and power are negotiated through the treatment of illness" (Greenway 2003, 93). She considered how class relations, political social and economical factors, conflict, exploitation and resistance (Baer 2003) factor in medical discourses. A compilation entitled *Medical Pluralism in the Andes* (Koss-Chioino *et al.* 2003), which includes a great deal of the recent work of ethnographers in the Andes, builds on Crandon-Malamud's work.

With increased research in the area, it became obvious that global processes affected local phenomena (Miles & Leatherman 2003). Indeed, research revealed that health and health care issues may be influenced by social and economic inequalities that stemmed from such global processes (Miles & Leatherman 2003) rather than by the inhospitable environment of the Andes. Crandon-Malamud (1991) builds on the idea that "medicine was

a resource through which people negotiated and expressed cultural identity and political and social power” (Miles & Leatherman 2003, 8).

The literature that followed replaced static perspectives from the past with recognition that access to social and material resources influences levels of health and possibilities for adaptation (Miles & Leatherman 2003). Models became more complex in response to a very complex issue, and included:

“...concerns about static reductionist models which tended to reify cosmopolitan biomedicine by naturalizing social phenomena, and the failure of previous models to address the role of historical and contemporary social relations in shaping perceptions of health and sickness” (Miles & Leatherman 2003, 7).

With a ‘reflective gaze’, researchers accepted biomedicine as a reflection of western culture, and moved away from “placing biomedically oriented value judgements on the ethnomedical ideas or health practice” (Miles & Leatherman 2003, 9). The realization that discourses surrounding health could in fact be understood as ‘metanarratives’ (Janes 1999) to express various social phenomena, led research on medical pluralism to consider how a broader set of factors affected health and health seeking decision making. Medical pluralism research in the Andes began to consider how the monetization of the Andes, and the increasing trend towards individualization played a role in the changing healthscape. Indigenous medical systems were also understood to be an important “source for revaluing cultural identity and a symbolic means of resisting the penetration of western capitalist ideology and social relations” (Miles & Leatherman 2003, 10). Medical dialogue and discourse, then, are used to express various aspects of social, economical, political or cultural situations (Baer 2003), and indeed it has been noted elsewhere that “biomedicine has become a metonym for modernity in the domain of healing” (Conner 2001, 7). Accordingly, this framework does not focus on medical systems as entities with strict boundaries, but rather on the *act* of seeking health care

as the point of departure of analysis. This framework also allows for the discussion of the vast amount of lay knowledge, self-healing and treatment in the home that takes place, which is considered by very few researchers even outside the Andes (see for example Finerman & Sackett 2003, Finerman 1989, Popay & Williams 1996, Wayland 2001).

Power inequalities exist between biomedicine and indigenous medicine, and also between indigenous medical practitioners and their patients (Crandon 2003, Miles 2003). It is perhaps this 'professional' bias that has led health research to focus primarily on medical practitioners and to disregard lay knowledge and healing, even though the home is where illness is first treated by members of the family (Baer 2003, Finerman & Sackett 2003, Pedersen & Coloma 1983, Wayland 2001). The researchers in *Medical Pluralism in the Andes* look at the variety of recognized traditional medical specialists, including bonesetters, herbalists, *curanderos* and traditional birth attendants, without considering lay knowledge of indigenous medicine. Although Miles and Leatherman (2003) claim that "this greater recognition of agency among participants in health systems is a key theme reflected in more recent medical anthropology in the Andes and the role of gender, class, and power in this negotiation is well recognized," (p. 10) they do not address the role of lay use of indigenous medicine. In the summary of medical pluralistic perspectives by Miles and Leatherman (2003) lay persons are only referred to in terms of their visits to the above specialists or their use of biomedical practices that range from "self-care with the use of pharmaceuticals to tertiary care hospitals" (Miles & Leatherman 2003, 9).

Discourses surrounding lay knowledge and local health care decision-making can be a source of insight into how people seek health care. This is important for PHC policy, given that many people prefer to go to pharmacies or seek home care rather than go to PHC clinics. Such insight may be helpful in redesigning PHC. Furthermore, Popay and Williams

(1996) argue that in light of global changes in health, where chronic illnesses are replacing diseases with controllable vectors and causes, it is necessary to move away from a purely biomedicalised view of health and foster a more holistic understanding that also considers lay knowledge. This research answers Miles and Leatherman's (2003) call for increased research concerning the "impacts of structural adjustment and privatization on health and health care delivery" (p. 11) but from the perspective of lay knowledge and local use of indigenous medicine.

### **5.3 Indigenous medical systems**

Indigenous medical systems and lay knowledge have a large role to play in responding to the effects of global processes on developing countries (Janes 1999, Popay & Williams 1996). Development, economic restructuring accompanying globalization and rapid shifts to modernity in many populations have brought with them unprecedented changes in health outcomes. While economic disparities grow, the wealthier and more aged sectors of the population are suffering from chronic, 'man-made' diseases such as diabetes. Health care systems are forced to deal with this burden at the same time as attempting to fulfill their obligations to treat infectious diseases that are common among the poor as well as mothers and children (Janes 1999). The pressures put on governments by international financial institutions to cut health spending complicate this condition. Pedersen & Coloma (1983) found that lay knowledge and informal health networks were a significant resource in disease management. Research and policies on public health need to include lay perspectives in order to be "relevant and sound and lead to more appropriate and effective policy and practice" (Popay & Williams 1996).

Public health research, influenced by biomedical methods, has been criticized for ignoring social factors that influence health, as well as overlooking the perspectives of people suffering from the diseases it was researching (Popay & Williams 1996). While it has made considerable advances in terms of epidemiology, biomedicine has been largely ineffective against chronic disease and man-made diseases, and in addition can be “alienating” and “dehumanizing” (Janes 1999, 1808). People in developing and developed countries alike seek alternative venues to manage suffering of chronic disease. Indigenous medical systems can offer “diagnostic discourses” (Janes 1999, 1807) that possess cultural meaning for patients that correspond to people’s cultural context. While this argument raises the question of medical efficacy, an exhaustive analysis of medical efficacy is beyond the scope of this discussion. It is nonetheless important to give a working definition for the purposes of this thesis. Janes (1999) defines it most suitably for the purposes of my argument:

If we accept the fact that a general definition of well-being is a significant aspect of medical efficacy and that a level of well-being is in part sustainable through medicine’s authority to construct for patients a culturally meaningful reality, then we must also accept that any medical system which works to provide such an experience for patients is effective (p. 1807).

Thus, efficacy has more to do with curative efficacy and alleviation of symptoms, and includes the perception of a particular therapy as having a positive effect on disease (Oths 2003), leading to a more desired state of being. With this framework for efficacy, Janes (1999) makes the case that indigenous medical systems need to retain their identity to deal with the rising occurrence of chronic diseases in both developed and developing countries. However, while Janes (1999) focuses on the importance of chronic and man-made illnesses that often affect the wealthier and elderly sectors of populations, the same argument can be applied to indigenous medical systems among the poor and rural, categories under which Añawi falls. Low income and rural sectors are increasingly turning back to indigenous

medical systems and lay knowledge as biomedicine becomes more and more unattainable for them. Being the most common form of indigenous medicine they use, Añawayans most commonly refer to medicinal plants when they speak of indigenous medicine. The following analysis looks beyond the well-accepted facts that medicinal plants are cheaper and more geographically accessible than pharmaceuticals in rural and remote locations, and examines the culturally embedded nature of their use at the household scale and the importance they hold for the community of Añawi. After a period of decreased use, Añawayans are not only turning back to medicinal plants for their own use, they are attempting to market medicinal plant products they make themselves. Here I address the discourses surrounding Añawayans' use of medicinal plants to show the many ways in which indigenous medical systems are important to low income rural people. These discourses are used to consider cultural aspects of medicinal plant use as well as to reveal other factors that affect the well-being of the community members.

### 5.3.1 The importance of medicinal plants for Añawayans

We come from dust, and to dust we will return. I believe that for that reason, we are attracted to the earth. The earth connects us all. As humans we have a connection with the earth, and I believe that without earth, humans cannot be happy or feel complete. The connection with the earth means that we are in contact with nature – plants and everything else the earth produces<sup>48</sup> (Interview 203).

The above quotation was an informant's response when asked about the relation between plants, humans and the earth. This response characterizes my findings that plants are and always have been an integral part of Añawayan life and their cultural identity, beyond their

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<sup>48</sup> *Somos del polvo, y en polvo nos vamos a convertir. Yo creo que por eso, algo que nos atrae la tierra. La tierra nos vincula (link, connect, bind). Tenemos un vínculo con la tierra, el ser humano, que yo creo que sin la tierra, no podría el hombre ser feliz o completo. Porque la tierra implica que el hombre está en contacto con la naturaleza – las plantas, todo lo que es en la tierra, lo que producen.*

use for medicinal purposes. There is a mosaic of medicinal plants on the landscape that grow at the various elevations of the village. There are also plants that grow at both higher and lower elevations outside the community. Plants at the higher elevations are often picked seasonally and prepared for the year<sup>49</sup>. People pick and prepare the medicinal plants that grow in their community very frequently, and the plants essentially constitute a layer of the healthscape. Medicinal plants have been used by previous generations and the only interruption to this has been the presence of western biomedicine on the healthscape. While grave illnesses have traditionally been treated by *curanderos*<sup>50</sup>, usually women and sometimes men treat everyday illnesses at home.

I found that when I asked people about medicinal plants, the discussion was rarely limited to medicinal plants. When people found out I was interested in medicinal plants, they were excited to tell me about the different uses for plants that grew in every crack and cranny of their community. I was told a plethora of stories of how plants were used before by their grandparents and ancestors. Various plants were used to dye fabric, bring prosperity to a home, wash clothes or hair, or used as barriers to keep evil spirits or pesky farm animals out of the yard. One type of plant was put in *chicha*<sup>51</sup> in order to become more intoxicated while a different plant was put in the drinks of men who consumed too much alcohol to make them stop drinking. Some plants were used to flirt with members of the opposite sex, or in matchmaking rituals, while other plants were used as indicators of the climate for the upcoming season and how the crops will grow. Those who were knowledgeable about plants were excited to share what they knew about them. They walked me around their

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<sup>49</sup> Such plants are often dried, made into tinctures, salves, ointments or teas.

<sup>50</sup> While most *curanderos* are able to treat a wide variety of illnesses, they are most well known for their treatment of culturally bound illnesses that have no counterpart in western society. Furthermore, the few practicing *curanderos* I met were a very heterogeneous group worthy of more discussion than I am able to afford in this thesis.

<sup>51</sup> a slightly fermented drink made of corn

gardens, showed me the wild plants that grew beside their fences and houses and how they used them. Plant knowledge was a source of pride for many, and the way people handled them and cared for them suggested a sense of affection and responsibility towards them.

Plants occupy a significant place in Andean beliefs, folklore and cultural identity. Several informants described plants as the children of the *Pachamama* (Earth-Mother), and therefore siblings to humans, reflecting the respect and importance plants hold in the community. Every year during the planting season, a ritual is observed whereby the *Pachamama* is paid an offering so that she will watch over the fields and livestock. According to Andean folklore, if she is not paid the fields may not produce and the *campesino* and his livestock can fall ill and die. Many Añawayans held plants in high esteem and some believe that the plants must be respected and their permission asked when using them as medicine. One informant who was particularly fond of plants and had a beautiful garden of medicinal and other plants described his plants as his children, and later as the children of God (Interview 120). Others told me that prayer must be used in conjunction with medicinal plants for them to heal. Many consider not only that medicinal plant knowledge is an inheritance from their ancestors, but that the act of using medicinal plants represents a direct link to their ancestors.

However, even though these customs abound in Andean folklore there was no clear consensus on the belief of Andean folklore concerning plants, and several Añawayans told me they no longer believed in the old ways. A common response to my questions concerning customs, traditions and folklore was “we almost don’t believe in it.”<sup>52</sup> Few people said it was necessary to ask the plant’s permission when using them for healing purposes. The same people that told me they ‘almost did not believe’ in the traditions told

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<sup>52</sup> *Casi no creemos en eso*



me they had still paid the *Pachamama* (I will return to this discord in the conclusion, reflecting a conflicted attitude towards Andean culture). This conflicting relationship within Andean cultural identity is a common theme among the discourses of Añawayans. Their comments reveal that they are conflicted between the desire to shed the old for the new and the desire to revitalize their cultural identity<sup>53</sup>.

People's narratives can reveal more than what they literally say (Greenway 2003), and my research participants in Añawi revealed conflicting feelings towards several other themes during our interviews. Añawayans often pitted medicinal plants against pharmaceuticals, healing at home against going to the clinic, traditional against modern, natural against chemical, thereby creating what appeared to be a dualistic worldview. For example, I was told that people were able to heal either with medicinal plants *or* with pills; they could either heal with the traditional way *or* at the clinic. When I dug beneath the surface, however, I found that the boundaries between such categories were not so impenetrable in everyday life. For example, people often resorted to pills, even if they had to sell animals in order to afford them, if the medicinal plants did not work. The relationship between the supposedly distinct categories of plants and pharmaceuticals, or traditional and modern for example, were blurry, messy and often conflicting. At the same time, Añawayans dualistic narratives reveal information regarding the relationship they have with their dynamic environment and the process of transculturation that has accompanied the monetization of the Andes as well as other global forces.

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<sup>53</sup> It is also possible that my presence as a white foreigner may have influenced their responses. The fact that they chose to tell me that they 'almost do not believe' is interesting in that it may reveal the identity they wished to portray to an obvious outsider. This also reveals that compatibility can shift (Madge 1998), so that when it is time to pay the *Pachamama* they do so, but in front of a white foreigner, they may feel it is in their interest to not believe so that they are taken seriously.

### 5.3.1.1 Thematic discourses: 'natural' versus 'chemical'

A common perspective I heard throughout my interviews with Añawayans was high regard for all that was 'natural'. According to Añawayans natural food products were smaller and had more nutrients than those grown with chemicals. 'Natural' was associated with 'healthy', and chemical was associated with 'contaminated'. For Añawayans, apart from being 'non-synthetic', the word 'natural' also implies something about the old way of life, how things used to be done. That which is natural is designated a separate category from the various other items that are 'unnatural' (plastics, synthetic, factory made) that have recently infiltrated their community. Añawayans proudly said that everything they ate was natural. By this they meant it came directly from their fields, where nothing but 'natural' manure from their livestock was used to fertilize, whereas the surrounding urban centres, in contrast used chemicals and pesticides to grow their crops. However, nearly all the rural communities at one time used chemical fertilizers and pesticides, when companies that sold these products provided them free of charge. Once they were no longer free and they had to purchase them, they could no longer afford them. The elevation of the status of 'natural' products, free of chemicals was one way to not admit that the chemicals were now (financially) unattainable.

Medicinal plants, of course, were associated with 'natural', whereas pharmaceuticals were regarded as 'chemical'. One informant told me the children were healthy because they eat natural foods, and therefore they do not have to go to the clinic very often. She told me that those people who eat naturally could cure themselves with medicinal plants, whereas those who do not eat naturally must similarly be cured with pharmaceuticals and go to the clinic. The example of contraception offers an example in the way Añawayan women pit natural against unnatural in the context of family planning.

Family planning campaigns along with the monetization of the rural economy have led many families in Añawi to desire fewer children. As in Larne's (1997) study in the Southern Peruvian Highlands, contraceptives seemed to be only offered sporadically in the CLAS clinic near Añawi usually in the form of IUDs, oral contraceptives and Depo-Provera<sup>54</sup>. I realized early in my research in Añawi that contraception was an important and debated topic in Añawi. I held one of my first interviews with a 34-year-old woman who had five children (Interview 109). Her children surrounded her as I interviewed her, and her infant constantly climbed onto her lap to nurse. She looked exhausted, and near the end of our interview she sat staring, with her breast exposed, and her nine year old daughter reached over to cover her up. The woman asked me how I 'looked after myself'<sup>55</sup>. Not understanding at first, she asked me how I managed not to have any children. I was surprised by this question, but after that whenever there were no men present, women frequently asked me if I knew any family planning methods that worked. I asked them about the methods they had tried, and they told me what they thought. They were disappointed because they wished they could have had fewer children. Furthermore, the doctors at the clinic told them not to have more children, but the contraceptives they were given either did not work or harmed them in various ways. Several women told me that after their last births, they had been given Depo-Provera or had been fitted with an IUD sometimes obligatorily or without them knowing. They told me that IUDs could harm them, give them headaches, painful stomach-aches or cramps. Depo-Provera, I was told, could 'shock their system'<sup>56</sup>.

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<sup>54</sup> Depo-Provera is a hormone injection that provides contraception for three months.

<sup>55</sup> The verb *cuidarse* was used in this case.

<sup>56</sup> The verb used here was '*chocar*'

I was also told that the Depo-Provera they were given in the clinic had passed its expiry date, and did not work. Several women told me that despite having had the injection, they fell pregnant, or told me of acquaintances to whom this happened. One woman told me that after a Depo-Provera shot she became ill (Interview 306). When she went to the doctor, she was told that she had a tumour, and that she had to go to Cusco to get it removed. However, when she got to Cusco, the doctors there told her that in fact she was pregnant. While she was telling the story she referred to her pregnancy as “a tumour that was actually a baby.” As a result of her not knowing she was pregnant, she said the baby was malnourished and had health problems when it was born, which is even more problematic than merely having one more (healthy) child.

I have no evidence that these stories are true. However, the narratives are perhaps more interesting and important than ‘truth’ because of the meaning they have for those who tell the story and those who listen. Such stories are told and retold throughout the community creating narratives that people draw on in making decisions. Añawayans trust their fellow community members more than the doctors in this case, and as a result of these stories of the harmful qualities of contraception provided by the clinic, several women told me they did not take contraception at all, because they were afraid of the adverse reactions and of becoming pregnant anyways. One family had just given birth to their ninth child. I was told that the family was keeping the child a secret because they were ashamed that they did not use ‘family planning’. This provided one more reason for people to mistrust the clinic, and as such, many of the women I interviewed inquired whether I knew of any ‘natural’ techniques of contraception. They told me their ancestors used plants and expressed the desire to use these ‘natural’ plants rather than ‘modern’ contraceptives.

The relationship Añawayans have with modernity is complex. While there seems to be nostalgia for certain aspects of what life was like in the past, there is also a longing for modern goods. While they often told me that plants heal and cure, compared to pharmaceuticals that only 'calm' an illness, people who had the means often purchased pharmaceuticals in the pharmacy rather than going to the clinic. While many Añawayans expressed the opinion that medicinal plants, and thus that which is 'natural', are superior to pharmaceuticals, or 'modern', they still desired modern goods. While many sought to revitalize Andean cultural identity through the elevation of the status of natural goods and old ways, many were of the opinion that they were better off now, and told me stories about how there used to be no doors on the houses only cow hides, that the roofs were made of tile now instead of straw, that the wool clothes they used to wear itched and were uncomfortable, and that now people washed their hair with shampoo or soap instead of human urine that had to sit in an urn and ferment for several weeks before its use. Some people, in particular the children who are now sent to school, have a sense of shame of their culture and ethnicity.

However, the desire for modern amenities will likely remain unfulfilled for the most part. The low prices that they receive for the few crop vegetables and animals they are able to sell in the market in the village impede them from participating meaningfully in the Peruvian economy. While plants may be the first treatment that is used to treat illness, people resort to other methods that are available if plants do not work. Despite the fact that pharmaceuticals are available, they are expensive and large financial sacrifices must be made in order to purchase them. The previously mentioned example of the guide I hired whose family was in debt due to the treatment of a fever that had plagued her whole family exemplifies this. Because pharmaceuticals are largely financially inaccessible to them, they

rebuke that pharmaceuticals in fact do not work; as in Bastien's (2003, 183) example, "to admit to [their] curing power is to recognize that positive treatments are available but unattainable." I heard a number of stories, some of which have already been referred to, that claim that after spending a great deal of money on pills and tests, or even being refused treatment by the local doctor because they did not have enough money to pay for the pills, they were treated by medicinal plants that cured them.

A related theme that was often referred to in my interviews was that of 'poverty'. Several people claimed it was their poverty that made them able to heal with medicinal plants, and more 'suitable' to the use of plants. Often medicinal plant information was revealed to them by praying to God, with the supplication that God help them because they are poor. Also, because they were poor and lived in the country they considered themselves strong and able to endure hardship, unlike the weak city folk who were delicate and could get sick at any time. Many expressed that the poor could heal with medicinal plants, while the wealthier had to be healed with pharmaceuticals. Victoria's story of her husband's illness is an example of this apparent difference between the rich and poor (Interview 115). Her husband had been sick for many years and was eventually taken to the hospital where they spent a great deal of money for pills and treatments that failed to cure him. When she brought him home, still ill and now very broke, she prayed to God who informed her that her husband was not meant to heal in the clinic, rather he was meant to heal with the medicinal plants from her back yard. She then treated him with medicinal plants, and he was cured. In this account, Victoria is able to transform the facts of being poor and pharmaceuticals being inaccessible to her as a source of pride, because medicinal plants had the power to cure him in the end. Furthermore they were free, and did not cause her family to go into debt. In such accounts, poverty is expressed as a term of pride and transformed

into a positive characteristic that gives them access to desirable resources, such as medicinal plants. Poverty is the reason they eat all natural foods from their own fields. Because they are poor, they are able to heal with medicinal plants. However, poverty can also be expressed as a source of frustration depending on the situation. When Añawayans want to visit the clinic or purchase pharmaceuticals and cannot afford to do so, or must sell their animals in order to pay for them, then poverty is obviously undesirable.

### 5.3.2 Transformative forces on indigenous medicine

Janes (1999) describes three main 'transformative forces' that can act on and endanger the identity of indigenous medical systems<sup>57</sup> in general. First, the increase of chronic disease and the dissatisfaction with biomedicine is increasing the demand for alternative (indigenous) medical systems. Second, such demands will increase government's needs to intervene and attempt to control indigenous medical systems. Most governments have biomedical health care systems in place, which will inevitably influence and perhaps attempt to control or medicalise the indigenous systems. And finally, in the face of growing privatization with neoliberal health care reforms, indigenous medicines and medical systems will "likely find themselves transformed in the competitive atmosphere of the private sector, where they must...compete for patient fees, sell medicines and support clinical facilities" (Janes 1999, 1810).

In Perú all three transformative powers have played important roles. In the urban centres, as chronic diseases have started to affect the middle class, elderly and wealthy, there is a renewed interest in indigenous medicines on the part of the affected populations. For example, as the rates of diabetes increase with changes in diet, there are several remedies that

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<sup>57</sup> This is not to say that indigenous medical systems are static and unchanging. They may incorporate other techniques, while retaining their worldview and local perspective.

appear in the markets that claim to either reduce blood sugar levels or heal diabetes outright. I was also told about an alternative practitioner in Lima who claims to have found the cure for diabetes and is currently making a small fortune selling this cure, but keeping it from government inspection<sup>58</sup>. Also, there are constant rumours among proponents of medicinal plants of the Peruvian government's threat to make the use of indigenous plants illegal by attempting to pass bills that are regularly stopped in congress. Such rumours seem to do little more than make the users of medicinal plants more fervent in speaking out in favour of their use, and make people more suspicious of the government. These are complex issues beyond the scope of this thesis.

The third force that Janes (1999) mentions, however, plays an important role in Añawi. To reiterate, Janes (1999) suggests that neoliberal policies and privatization will drive the use of medicinal plants into the competitive private market. As I mentioned earlier, however difficult it was to get to clinics in the past, the cutbacks in rural services and resulting user fees instigated by the CLAS have made it increasingly difficult for the poor and rural to obtain medical consultation and pharmaceuticals. As a result, many have turned back to indigenous medicines. However, because the doctors attempted to force people to use PHC clinics in the past, and various NGOs and tourists gave people pills for free, many people have either forgotten, not learned or learned very little about the local indigenous medical system. Many found themselves in the difficult position of not being able to afford health care, and not possessing the knowledge of how to use indigenous medicine. With the help of IEPLAM, 47 of Añawi's 225 families are starting to rebuild their knowledge of medicinal plants. Both the loss of knowledge as well as Añawi's interest in IEPLAM have been transforming forces on indigenous knowledge.

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<sup>58</sup> I heard this from several sources including, market herb vendors, professionals in Lima, and a *curandero* in Chiclayo on the north coast of Perú.



### 5.3.2.1 Loss of knowledge

In many areas it has been noted that a loss of traditional medical knowledge and practices accompanies the introduction of occidental medicine and associated cultural values, and is part of a larger process of transculturation (Browner 1989). For example, Browner (1989) observed in Latin America that among indigenous people living closer to larger urban centres where biomedicine had taken precedence, there was a loss of knowledge and confidence in traditional medicines. In this case pharmaceuticals were used for common illnesses where medicinal plants were previously used because pharmaceuticals were reported to be more effective and act more quickly. Such examples reveal how interactions at various scales, geography and monetization of rural economies can affect indigenous societies in traditional knowledge production.

Many people I interviewed in Añawi claimed there was a general loss of indigenous medical knowledge in the community due to a variety of factors. The presence of PHC clinics and the enforcement of their use, rural to urban migration, as well as transculturation and monetization of the rural economy caused a break in the oral transmission of medicinal plant knowledge for many in Añawi. The loss of knowledge was not homogeneous among all community members, and among those who were members of IEPLAM, loss of knowledge appeared to vary according to three main factors: the proximity of the families dwelling to the larger village, their relative wealth as compared to the rest of the community, and the age of the person.

Being located on the slope of a mountain, those that lived at lower elevations were closer to the main village and were subsequently more affected by the policies that pressured *campesinos* to go to the clinics at the onset of ill health. This appeared to lead to a higher loss of knowledge of indigenous medicine compared to those that lived at higher elevations. In

fact, several of my informants that lived at higher elevations claimed never to have visited the local clinic, and spent less time in the village. One informant told me that when people move to the city to work or go to school, they become '*despierto*' (sharp, alert, awake) and are thus no longer interested in traditional knowledge (Interview 101a). He confided that as the education system draws children away from farm work into schools, they do not want to live in the community any longer, because there is no money to be made in the fields in the community. Also, more time at school means less time at home learning skills such as how to use medicinal plants. Whereas such practical knowledge may have been critical in times when there were no clinics, more importance is now given to earning more money in order to purchase pharmaceuticals or go to the clinic. As they move to urban centres due to the perception that they can earn money there, they "get to know chemical pills" (Interview 107). This informant told me that when they start using pharmaceuticals, medicinal plants can no longer heal them, and they forget about them. Other informants also point to a loss of knowledge that comes with more money (because they can afford pharmaceuticals), or the cultural transformation of leaving rural life for the modern amenities that an urban lifestyle can potentially provide.

With monetization of the rural economy and a preference for modernity comes disregard for 'tradition'. One informant told me that the children are only interested in that which is easy to accomplish, and various informants told me that most children no longer want to take part in traditional customs. This interview excerpt is from a resident of Añawi who is telling me that the children are ashamed when their parents pick them up at school wearing traditional clothing:

When I wear traditional clothing<sup>59</sup>, they are ashamed of their origins. They tell me that their friends would make fun of them saying that their father is a *cholito*<sup>60</sup>. So my children tell me, “papa, change your clothes seeing as you earn money.” Now it has changed, and we have left all of that. We used to have festivals, but even that we have given up<sup>61</sup>. (Interview 101a).

The same informant told me later that now the people in the communities have become more educated and as a result have become *mejorados* (‘improved’), many people have a sense of shame of their traditions, and consciously leave it behind to embrace more modern practices. For example, most people in the village wear western clothing and aspire to make money to purchase items, and many young people have left the rural life for the cities, because there are no jobs or money to make in the community. Many of the adults in the community lament the fact that the children do not want to stay in the community, that they are no longer interested in such things as medicinal plants, and that medicinal plants are seen as part of an ‘old way’ that they are attempting to discard. Accordingly, many of the younger people also prefer to use pharmaceuticals to alleviate illness instead of using medicinal plants. Regardless of these changes, though, Añawayans made it clear that medicinal plants and plants in general played a significant role in their lives.

### 5.3.2.2 IEPLAM (*Instituto Ecológico de Plantas Medicinales*)

Despite the apparently dualistic nature of Añawayans’ discourses surrounding the themes that have been presented here, Añawayans struggle to reconcile their yearning for that which is traditional, Andean and ‘natural’ with their desire for modern amenities, which

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<sup>59</sup> This refers to the colourful hand-woven poncho and hat the men wear, and the skirt and *manta* (shawl), and hat the women wear.

<sup>60</sup> *Cholo* or *cholito* usually refers to someone with both *mestizo* and indigenous attributes. *Mestizos* often use this term to refer to indigenous people in a derogatory or insulting manner.

<sup>61</sup> *Quando llevo la ropa típica, los niños tienen vergüenza de sus orígenes. Dicen, ‘mis compañeros nuevos dicen que mi papa había sido un cholito’, no? Entonces los niños dicen ‘papa, cambia tu ropa, comprar como gana platita.’ Por eso tiene que ser cambiado entonces, toda la ropa se había dejado pues. Así es, porque ¡antes bonita era! Por ejemplo fiestas había... también las fiestas hemos un poco dejado ya.*

necessitates their participation in the monetized economy. One way several members of the community are attempting to participate in the economy is through their involvement with the research institute, IEPLAM that promotes the ecologically sustainable and culturally relevant reintroduction of medicinal plant knowledge into rural communities.

Since the early 1990s, various families in Añawi and other surrounding communities had been selling branches of a bush the locals call *arrayán* (*Luma chequen*)<sup>62</sup> to IEPLAM. IEPLAM financially supports itself by distilling an essential oil from this plant and selling it to a German company as a natural preservative. In 2001 the families that were selling *arrayán* approached the research institute to ask what the *arrayán* was used for, and eventually decided to become more involved with IEPLAM's activities. The families formed a *Comité de Plantas Medicinales*<sup>63</sup> and registered with the Municipality of Paukcha. IEPLAM had been established for 11 years at the time of this research. It was working with around 500 families in 20 different communities throughout the Andes. Little by little the communities that sold *arrayán* to IEPLAM have become involved more extensively with this research institute by creating medicinal plants committees through which they make and sell medicinal plant products with IEPLAM's support. Several families in Añawi did the same in 2001 after selling *arrayán* to IEPLAM for 9 years. A total of 47 out of the 300 families in Añawi are involved. In 2002 the Medicinal Plant Committee applied for a grant from UNDP, which granted them enough funds to construct a building and purchase gardening tools, a small stove, a still to produce essential oils, as well as a basic lab to dry and produce teas, tinctures and salves. Since then, they conduct regular meetings, meet with other communities involved with IEPLAM, participate in workshops in which they learn and share knowledge

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<sup>62</sup> *Arrayán* is not native to this area, but was planted several years previously as part of a soil conservation project.

<sup>63</sup> Medicinal Plant Committee

about medicinal plants, and learn how to make the aforementioned medicinal plant products. IEPLAM offers educational support and logistical advice while resisting the temptation to 'buy' the campesinos' participation as so many NGOs, government agencies and private companies have grown accustomed to<sup>64</sup>.

It may be inaccurate to generalize Añawi's overall enthusiasm for medicinal plants to other villages. However, similar connections and alliances between rural community groups and external organizations are becoming more common in the Andes. The association between Añawayans and IEPLAM likely sets them apart from other rural Andean communities with regards to indigenous knowledge of medicinal plant use. More specifically IEPLAM has transformed Añawayans' attitude towards indigenous knowledge of medicinal plants in multiple ways. For example, IEPLAM has indeed increased both people's knowledge by refining their existing knowledge of local plants, as well as introducing information about plants from different regions of the country. IEPLAM has elevated the perceived status of indigenous medicine in Añawi, thus offering more independence from the clinic and expensive pharmaceuticals. Additionally, IEPLAM has mobilized the community around a communal project, and in this sense it fosters social networking. It has also led the community members to consider their medicinal plants products as a means to financial improvement. Finally it has put gendered power relations into question by elevating the status of medicinal plant-related work, commonly perceived to be women's responsibility.

The main goal of the founder of this research institute is to elaborate the idea of ecological sustainability while giving communities a chance to learn more about medicinal

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<sup>64</sup> Many such organizations offer the *campesinos* small gifts or supplies for their participation in projects. Many lament the fact that the *campesinos* have grown accustomed to this practice, and refuse to participate without monetary or material gifts.

plants, as well as making them financially independent through the sale of medicinal plant products they produce. The main goals of the families that were involved in IEPLAM fell under two themes. Many wished to learn more about how they could use medicinal plants for their family and become more independent from the clinic, and others placed more importance on making money from the sales of their medicinal plants products. Out of 22 respondents, 50% said the most important aspect of their involvement with IEPLAM was that they learned more about healing themselves, and 14% said it was the second most important aspect. This compares with 41% who said making money was the most important aspect<sup>65</sup>. Most of those who said making money was the most important aspect lived within the lower elevations of the community, and thus closer to the larger village, whereas most of the respondents that lived higher up in the village, with less access to the larger village said the most important aspect of IEPLAM for them was learning how to cure themselves and their family members. It was more difficult for them to get to town to visit the clinic, which may explain a greater desire for independence. Also, while both responses can be understood in terms of money, those living closer to the village had more of a desire to make money by selling their plants and furthermore the closer to the market one is, the easier it is to sell one's goods. Those living at higher altitudes had more of a desire to save money by not having to purchase pharmaceuticals or make the trip to the village clinic. The rise in clinic fees is one factor that fuelled people's desire to learn more about medicinal plants. Some people told me that they knew very little about medicinal plants until they became involved with IEPLAM, and in some cases the education they received with

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<sup>65</sup> 5% said it was the second most important aspect. Other categories: 1 person said that IEPLAM would be a good inheritance for their children is the second most important aspect, 1 person said training for women was the second most important aspect, 1 person said the social aspect (gathering, working together) was the most important aspect, and 1 person said it was the second most important aspect, and finally one person said it was because they loved plants

IEPLAM helped them to refine their knowledge of medicinal plants. For example, one informant told me that her mother always told her to boil herbs to make medicinal teas. With IEPLAM she learned that boiling can destroy the medicinal properties of some herbs, and that they need to be merely steeped. In other cases, during workshops, they learned about different kinds of plants from different regions that were used by different people. In this way, IEPLAM has fostered the creation of lay referral networks.

Several people that worked with IEPLAM mentioned the social aspects of gathering with community members as a positive outcome of their involvement with IEPLAM. Such positive outcomes can lead to the building of social capital and social networks, and further involvement of community members. Several women I interviewed told me they liked working with the committee because it gave them a chance to get out of the house and leave their never ending work there. I was also told that before they created the committee, people would lie, steal and rob from one another in order to sell more *arrayán*. Now they work together, each person having to fulfil a set number of hours of work for the common good of the committee. Some people mentioned that it just made them happy to work together with community members, and with plants. During my research, I was able to witness one committee meeting. After the meeting, we shared a neon-coloured *gaseosa*<sup>66</sup> and then worked in the gardens. I sat down with a number of women I had already interviewed and picked camomile flowers with them. As I was no longer the interviewer, and they were teaching me how to do something, a colourful and comical conversation ensued with much laughter. The medicinal plant committee was esteemed to be a desirable organization to join. On several occasions, mistaking me to be involved with IEPLAM, I was asked by non-members from both Añawi and other villages that worked with IEPLAM how they could

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<sup>66</sup> Soft drink

join. This suggests the importance of such an organization beyond its immediate goals. Also, because people see it as a desirable committee to join, its presence may have more influence in the community and may lead to more and more people joining and agreeing with its principles.

Their greater participation with IEPLAM has increased community involvement, knowledge about medicinal plants among participating community members, production of medicinal plants, and alliances with external organizations. At the time of the research a number of alliances with the community and external organizations were being put into place. For example, a (biomedical) hospital in Cusco, with a section for indigenous medicine, had recently contracted the community to grow medicinal herbs for use by the hospital. Such contracts and contacts will increase the production of medicinal plants, changing the landscape of the community. It is uncertain how the alliance with a biomedical hospital will affect their medicinal plant committee.

IEPLAM has also raised issues of gendered power relations in Añawi. To some degree it has altered female / male relationships as well as affected gendered aspects of knowledge of medicinal plants. While some studies have shown very little difference in medicinal plant knowledge along gender lines (Izugbara *et al.* 2005), many others show that women are more likely than men to possess knowledge of medicinal plants as they are largely responsible for social reproduction (Browner 1989, Madge 1998, Wayland 2004). However, in Añawi, during my interviews I found that many men were knowledgeable on the subject of medicinal plants, many people had learned about medicinal plants from their fathers, and just as many young boys accompanied their parents to IEPLAM gatherings as young girls. In fact, some men were cognizant of medicinal plants used for women's menstrual problems and pregnancy. The founder of IEPLAM informed me that when he first went to the village



to propose that they start a committee on medicinal plants, both men and women came to the meeting (Interview 401). From the second meeting on, however, the men's presence dwindled until the committee was made up only of women. When he asked the men why they no longer came, the founder was told that planting and collecting medicinal plants was women's work. After some time, the women started to make a little income with their medicinal plants products. One day the founder came to his office in the city to find a group of men with sheepish looks on their faces from the village waiting for him. They asked him if they could join the medicinal plant committee, because they had seen that it was profitable, and also wanted to make money. The founder told them that it was certainly not up to him, but to the women that established the medicinal plant committee. The men were then forced to ask the women's permission to be included in the medicinal plants committee.

This has given the women a sense of empowerment and independence. Also, it has changed men's attitudes towards women. Since the women were the ones who knew more about medicinal plants and were starting to make money, the men had to support their activities. However, this varied among families. For the most part, women participate in the medicinal plant committee, but because women have a heavier work burden than the men, sometimes the men attend in the women's place. The men will not take over the women's work in the home while she is away, so she merely has more to do when she comes home, thus, in some families the men are more involved with the committee, essentially taking power back into their hands. At the time of this research, men held the more powerful positions in the committee. It is difficult to discern to what extent it was accepted that men also transmitted medicinal plant knowledge before the presence of IEPLAM, but there is evidence that the activity garners respect and men openly discuss their knowledge of medicinal plants.

Community members that lived at lower elevations in the community and closer to the village placed the potential economic return from medicinal plant products as the most important aspect of their involvement with IEPLAM. The discourses surrounding this view reveal insights about their economic situation as well as the transculturation that is taking place in their communities. Many of these people told me explicitly that their main concern with IEPLAM was about earning money. They spoke a great deal about ‘valuing’ (*valorizar*) the plants that grow wild in their community. When I asked one woman if they used medicinal plants before they were involved with IEPLAM, she responded:

We always had them, but we didn’t know how to value them. We just used it [*arrayán*] as firewood. We didn’t know what it was good for. But now we know how to value the plants, and now we look after every little plant. Before we didn’t. Before we didn’t have any income, not even one single *sol* fell on the place. But now we earn a little [by selling *arrayán*], and sometimes we have enough to buy sugar if we want to<sup>67</sup>. (Interview 103)

Another person’s response to the question of how she treated illness before they were involved with IEPLAM was exemplary of many within my sample. The response corroborated the above informant’s implications of ‘*valorizar*’. This informant responded that before IEPLAM they did not know anything about medicinal plants and that they were merely *botado* (thrown away) and not useful. She went on to tell me that *arrayán* was traditionally used as a preserving agent for the skin and to wash the dead. I pushed further to ask how ill people were treated before they died and she told me a litany of medicinal plants remedies that were used. Clearly, for this informant ‘*valorizar*’ refers to the importance of the economic return of medicinal plants. While *arrayán* may have held practical value for people before they started selling it, they place more importance on it now as it brings them

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<sup>67</sup> *Siempre tenemos, pero no sabíamos valorar. Eso se utilizaba para leña. No sabíamos para que servía. Pero ahora ya sabemos valorar las plantas, y cuidamos cada plantita. Pero antes no. Antes no teníamos ingresos, no tenemos ni un sol que nos caía al lugar. Ahora ya vendemos y ya tenemos algo para azúcar siquiera.*

money. This sense of value also applies to their sense of satisfaction of learning about traditional healing methods because it saves them the money they would otherwise spend going to the clinic in the face of ill health. Several of my informants told me that learning about plants was valuable because plants did not ask anything in return; one could just pick them for free, and not have to spend money on pills. The transition of 'value' being something practical and useable to something that brings in extra money reflects a change in priorities and the monetization of their economy.

To illustrate the effects of this shift in priority, another informant told me that before the presence of IEPLAM, Añawayans used to share medicinal plant information freely, and let anyone pick medicinal plants on their land, but now that plants are worth money, they do not allow it (Interview 133). Production for external consumption has caused changes in both knowledge transmission and sharing. Such changes, for example, have led to minor conflicts in community territory. Añawi shares a property line with Chaqollu, a community that lives higher up the mountain. This community is generally poorer than Añawi due to their limited arable land. They rely mainly on the potatoes they grow and llamas they raise to barter or sell for other items or services they need. Recently, with the rise in popularity of medicinal plants, women from Chaqollu pick high elevation plants to sell in markets in neighbouring villages. In most cases all parts of the plant, including the roots, are used and this has led to scarcity of many of the slow growing high elevation plants. Thus plant collecting has become more and more competitive, and women have recently ventured into the community of Añawi to collect plants. This of course has caused many in Añawi to grow concerned that the medicinal plants they use may become endangered. At the time of the research, Añawayans were starting to draft an official letter

to the local municipal government requesting the protection of their land from outsiders picking medicinal plants, by penalty of a fine.

While the presence of IEPLAM has had a transformative force on indigenous medicine, Añawayans are very enthusiastic about their work with the committee as it fulfills a number of their needs and desires when it comes to not only health care, but to a broader set of factors that affect their overall mental, emotional and material well-being. With this increased knowledge, people are more independent from both biomedical practitioners as well as traditional practitioners. Likewise, the social mobilization and sense of well-being that IEPLAM incites may lead it to hold a stronger position within the community and may in turn motivate people to learn more about medicinal plants. Furthermore, it has caused Añawayans to re-evaluate what is commonly thought of as 'women's work'. IEPLAM promotes and supports their cultural identity by demonstrating the 'value' of their indigenous knowledge. It offers the possibility of a certain level of independence from the PHC medical system that has been imposed on them, and presents the potential for them to earn money and thus manage the financial obligations that the monetization of the rural economy has presented them, such as education for their children and health care. As a result, Añawayans involved with IEPLAM consider medicinal plants to be a very important part of their lives. If Andeans are indeed risk adverse because of dependence on their crops and animals, and are not fond of external institutions instructing them on how to manage their health, how has IEPLAM been able to receive such a positive response? How has an external voice persuaded them to re-evaluate their agricultural livelihoods to grow, harvest and sell medicinal plants and re-educate them about what Añawayans would consider to be *their* ancestral knowledge?

Añawayans are enthusiastic about IEPLAM because it reconciles a number of conflicting notions that represent the complex relationship that they have with modernity and the transculturation that is happening throughout the Andes. Many of the themes that are presented here were expressed by people in a dualistic fashion by pitting one theme against the other: natural versus chemical; traditional versus modern; one can either heal with plants or with pharmaceuticals; plants heal, pills do not. However, there were interesting conflicts that revealed the recursive effects of the global forces of transculturation on the local. For example, the informant that expressed nostalgia (Interview 101a) for times past complained shortly thereafter that more money was needed in the village without realizing that more money means more change. One informant (Interview 107) expressed pride in her poverty, saying that it made her strong and knowledgeable about her land and medicinal plants, whereas city people were weak, and while they may have money, they have nothing else. Only minutes later, mistaking me for someone who had access to governmental institutions, she pleaded me to tell the government agents that they were in desperate need of money and resources in their community, because they were poor, and thus were worth 'nothing'. The guide I hired to translate for me revealed to me only near the end of my research that she and her sister ran a small convenience store in her home. During the days that we worked together, she talked at length about the benefit of living in the country, where they ate naturally, and were always happy, and never went to the clinic because they only ate food that they grew themselves. Yet when she showed me her store, she opened a bottle of *gaseosa* and a bag of sugar cookies to share. She sold rice, pasta, *gaseosas* and little cookies, foods that were commonly purchased for festivals. This was surprising, seeing as most people considered festivals to be part of that which was 'traditional', thus aligned with 'natural'. I was also surprised when at the end of the medicinal plant committee meeting a

bottle of *gaseosa* was purchased and passed around like a luxury item. These conflicting narratives are not meant to malign Añawayans, but to demonstrate the discord and difficulty of living in a situation where there are amenities to purchase, but no purchasing power. The fact that IEPLAM offers a potential to reconcile this makes it a powerful and desirable institution for Añawayans to be involved in. While supporting and restoring confidence in the cultural and ethnic identity by reifying and elevating the status of medicinal plants (the knowledge of which represents of a direct line to their ancestors), IEPLAM also offers the potential to increase their income, thereby giving them more access to modern amenities.

That said, the fact that Añawayans are very focused on the economic return of their medicinal plant products might have repercussions and present barriers to the sustainability of IEPLAM. Several of my informants had unrealistic expectations for their medicinal plant products. For example, one informant (Interview 133) told me that one day they would bring their products to the local three-star hotel that catered to the few rich tourists in the area. She spoke as if the committee merely had to bring the products to the hotel, where the products would easily be sold and the committee would make a great deal of money. Others were certain that they could either sell to tourists or internationally. Many of them had visions of making fast and easy money with their medicinal plant products, but there are significant barriers to this. First, the packaging of their products was insufficient to ensure a returning clientele. The packaging was cheap and frail, and many of the samples of salves of essential oils I bought leaked. Also, while there were many possible opportunities to sell to tourists<sup>68</sup> or to propose their products to the local CLAS, they made no attempt. There was

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<sup>68</sup> Many tourists that come to Cusco and surrounding areas are interested in indigenous culture and products

a popular tourist market in the village, and ruins visited by many tourists in the area, but they did not attempt to sell their products there<sup>69</sup>.

Janes (1999) warns of indigenous medicines becoming merely a list of herbal concoctions with no cultural reference and context. There is evidence of this occurring in Añawi. As many Añawayans are extremely concerned with the money they may make, there is less attention to cultural context that surrounds the use of medicinal plants. For example, the president of the medicinal plant committee was invited to show their medicinal plant products at a fair in Lima that featured medicinal plants and other products from the Andes. Previously, with the help of the founder of IEPLAM, they collected remedies and stories of the local medicinal plants in a book to sell to the public and for each member of the committee to have a copy for reference. The president of the committee had not looked at the book in preparation before going to the fair, and was embarrassed when after the first day he could not answer any of the questions that people asked him about the plants.

While Añawayans are taking a renewed interest in medicinal plants, some of the cultural and social aspects of indigenous medicinal plant use continue to be lost, and in some cases only the list of remedies remains. Although the founder of IEPLAM tries to promote the cultural context of indigenous plant use, it can be argued that the economic benefits that IEPLAM offers trump concerns of cultural relevance and the 'learning' aspect of medicinal plants. Also, this revitalization of medicinal plants knowledge is occurring in a more capitalistic and entrepreneurial framework. Further research needs to be conducted to

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<sup>69</sup> One possible explanation for this is that, as mentioned earlier, Andean people are somewhat risk averse due to the nature of their environment. As such, because they depend on their crops and animals for their very survival, these obligations come before all else, and make it difficult for them to pursue new ventures. Many of my informants said that if they had more money they would plant more plants, and spend more time trying to develop IEPLAM, but at this time, it is deemed too risky for them to give other things up.

measure the effects this has on indigenous medicine and power relations surrounding indigenous medical knowledge.

## 5.4 Conclusion

While the notion of medical pluralism has been recently favoured over theories that traditional medicine should be integrated into biomedicine, people in Añawi still feel the repercussions of being pressured to using PHC. User fees make PHC increasingly difficult to use, however, many people no longer retain the indigenous knowledge of medicinal plants. Añawayan discourses surrounding the use of medicinal plants and their vocal preference for medicinal plants over pharmaceuticals and the clinic can be understood as a site of contestation. In their declaration of preference for medicinal plants over pharmaceuticals, they are also declaring (in part) their discontentment with government-sanctioned PHC and desire for independence from it. This preference can also be understood as a site of cultural identity (re)creation, seeing as medicinal plants are understood to be an inheritance from their ancestors and representative of Andean culture. The discourses and narratives surrounding the use of medicinal plants reveal the dynamic nature of their current cultural situation where there is a mix of old and new, of 'traditional' and 'modern'. They reveal the complex and conflicting relationship Añawayans have with the flood of western goods and modern amenities and in this context, biomedical PHC clinics and pharmaceuticals. Añawi's involvement with IEPLAM reconciles this complex relationship through the promotion and revitalization of cultural identity and at the same time, offers them the potential to increase their participation in the economy and thus negotiate the ever more monetized economy of the Andes.



## Chapter 6: Conclusion and implications

### 6.1 Conclusion

This thesis examines cultural identity and the struggle for power at the interfaces of a PHC clinic and the local indigenous medical system. While my research participants occupy a pluralistic healthscape, they rely on two principal approaches to manage their health: the local CLAS clinic and medicinal plants. I have discussed the CLAS system from the perspective of both health care workers and *campesinos* in a rural community that the clinic serves. I have examined the *campesino's* local knowledge of medicinal plants with a focus on medicinal plants. I look at the role that medicinal plants occupy on the Añawayan healthscape, as well as the discourses and narratives surrounding their use.

The CLAS program's original mandate embraces comprehensive goals: it was created to provide for the basic health needs of the poorest sectors of Peruvian society. Community participation and administrative decentralization are key features of this program. The CLAS program includes a focus on non-income generating health services, as well as a policy of cultural sensitivity toward local indigenous and *campesino* populations. Despite having comprehensive goals, the CLAS is more characteristic of the selective approach to PHC, and appears to prioritize efficiency over equity. The CLAS is organized as a private health system, relies on user fees from patients to finance all costs of the clinic except for the salaries of the essential health care workers. Consistent with the selective approach to PHC, the GOBI and FFF interventions are emphasized in service provision.

The implementation of user fees has marginalized low-income sectors of the society. Regardless of how inexpensive the user fees appear to be to those in the Ministry of Health who designed the program, they represent a significant percentage of the insignificant (and sometimes non-existent) earning of low-income sectors. The CLAS cannot claim to be part of a poverty reduction strategy when poor *campesinos* must sell their animals or go into debt in order to get services. In addition, the CLAS has not met its goal of increasing coverage for low-income rural sectors. The CLAS clinic works best in areas of either higher or mixed income, where there is a sector of the population that are able to pay user fees, which enables the clinic to exonerate fees for the most poor. In rural areas, where most of the sector is poor, the CLAS is not financially sustainable. It follows that in such situations the overt promotion of the SIS insurance and the exoneration of fees are not in the clinic's interest. While the CLAS system poses as comprehensive PHC, it is better seen and will be more effective as *selective health care*.

The CLAS promotes decentralization as a tool for empowerment of local communities. However, decisions concerning health programs and promotions continue to be conducted centrally rather than by the community. Additionally, the community participation promoted by the CLAS is limited to administrative participation only; therefore, educated community members most often occupy this role. While this can function in urban settings where the population is more able to undertake such a role, this is not the case in rural settings. *Campesinos* do not often have the education necessary to fulfil this role. As such, community elites often occupy this role, reinforcing power relations within the community. This research has revealed that in some cases, these participants occupy only an honorary role, and do not participate in a meaningful way. This is neither beneficial to the community nor the clinics, since the managing doctor must fulfil this role in

addition to his or her regular duties. Within the CLAS mandate, community participants have the responsibility to make decision regarding health programs and the functioning of the clinic, but there is little evidence in this research that they actually do so. Community participation in administrative tasks seems unrealistic in areas where people do not have the necessary skills to conduct administrative duties. However, there are a number of other duties that locals could engage in: translating, welcoming and admitting patients, and providing indigenous health care or cultural knowledge. The position of 'elected community participant' would be more meaningful if the position were remunerated at a level that reflects local community members' incomes. In Añawi, I was told that the local wage for a day's work outside the village was approximately seven to ten PEN (CAN \$2.40 – \$3.4). A comparable wage may not attract local elites, but may attract local *campesinos*. Remuneration may also lead to more meaningful community participation in which the community is actively and practically involved in providing health services for the community. Future research should explore the feasibility of such endeavours.

The CLAS claims to foster cultural sensitivity among health workers. In my research, the two primary methods for achieving this were requiring health workers to speak Quechua, and allowing *campesina* women to practice traditional birthing techniques. I argue in this thesis that although a significant step, these methods are more useful in procuring patient compliance than fostering meaningful levels of cultural sensitivity. The requirement that health workers speak Quechua does not necessarily result in cultural sensitivity. As for birthing techniques, health workers practically force rural women to give birth in the clinic regardless of many women's preference to give birth at home. There are posters and charts in the obstetrician's office that have the name, geographical location, and due date of every expecting woman in the area that the clinic services. If they do not arrive around their due

date, the obstetrician arranges to persuade the woman to come to the clinic to give birth. By allowing traditional birthing techniques, it is easier to persuade women to come to the clinic to give birth. However, there was no accompanying sense of respect for the local perspectives concerning birth giving, or acceptance that a woman should be able to make her own choices in how she wishes to give birth. Furthermore, the increase in number of births in the clinic tells us nothing about the women's experiences. Miles (2003) argues, "despite the discourse of 'care' and 'altruism', health systems are commercial enterprises and manipulate locally meaningful symbols of power and efficacy to further their success" (p. 115). The health workers in my sample *were* caring individuals working in a system that forces them to act like a business, creating a conflicted position. Meaningful awareness of cultural sensitivity for the sake of the patient's wellbeing, rather than merely increasing patient visits to the clinic does not only mean understanding different perspectives of health and nosology, but also respecting and fostering those ideas, with the understanding that biomedicine too is an expression of the culture in which it arose.

I argue that by failing to address the needs of poor rural *campesinos*, the CLAS program has contributed to a revitalization of indigenous medicine. However, the many years health workers insisted people visit the clinic has been a significant factor to the overall loss of knowledge of indigenous medicine in Añawi. As such, indiscriminate use of indigenous medicine may be the result of this revitalization. The Ministry of Health must give attention in the form of funding and support to the '*capacitación*' and education of indigenous medicine. However, local communities rather than occidental biomedical practitioners must organize this. An increase and spread of indigenous medical knowledge would increase people's capacities to manage their own primary health needs, and would save costs to clinics. This shift in the power that accompanies health knowledge being in the

hands of community members is necessary for people to be responsible for their own health. As Madge (1998) argues, “the ultimate aim of any health care strategy should be to increase people’s control over the improvement of their health and towards achieving this aim; indigenous health care is worthy of greater respect in biomedical discourses and practice” (p. 309). A meaningful method of community participation would be to foster an educational network with this goal in mind. This would not work within the CLAS framework; however, increased self-reliance for health needs may lead to a decrease in clinic visits, and thus a decrease in profits.

It is likely that the CLAS and other expressions of health sector reform will remain the primary source of PHC in the near future (Hall & Taylor 2003). Therefore, the CLAS should be seen for what it is, a medical enterprise driven by financial and commercial imperatives that attempts to maintain its authority through control and power relations (Miles 2003, Wayland 2003). In urban settings where the population has a higher economy, there is evidence that the CLAS system is successful. However, in rural populations, where the overall economic level of populations is low, the CLAS system as it is currently organized is not feasible. Therefore, it should not claim to constitute a comprehensive approach to PHC. In fact, in rural areas, the CLAS system operates more like a selective health system for the rural poor, who are likely to look after PHC in their own homes and communities. It follows that the integration of traditional medicine into the CLAS system is neither viable, nor would it necessarily be desirable considering the cultural divide between the two systems.

In Añawi, people struggle for power and autonomy on the healthscape through their health care choices and practices, which reveal their cultural identity and positioning

(Crandon 2003). The discourse they employ of ‘plants heal, pharmaceuticals calm’<sup>70</sup> serves to maintain their cultural identity as those who ‘heal from plants’. It concretizes their identities as poor, rural, *campesinos* who eat natural foods, and are resilient, which in turn contrasts them with their lighter-skinned counterparts or “oppressive elites” (Koss-Chioino 2003, 20), who are frail, eat ‘non-natural’ food, and are limited to using expensive pharmaceuticals that only serve to alleviate symptoms, while the disease lingers, waiting to reappear. This reifies their position as ‘practical people’ and *campesinos* who are able to live off the inhospitable land. Their emphasis on the preference for medicinal plants also served to renounce the clinic, so that healing choice is an act of political resistance (Greenway 2003). Such discourses bestow power and prestige on their form of healing over the medicine of an occidental origin, and subvert the power of pharmaceuticals by rendering them powerless against disease. In addition, many of my research participants, especially women, told me that the doctors treated them rudely and insulted them. By preferring to treat illness at home, they are also rejecting this source of power relations. Accordingly, Miles (2003) argues, the type of healing system in a place is not haphazard, but “reflects localized understanding and controversies about how the social world is constructed, how and where power and influence are manifest” (p. 110). It is important to note, however, that despite their preferences, they make pragmatic decisions about their health and do what it takes to deal with illness<sup>71</sup>.

Añawayans involvement with IEPLAM and the creation of the medicinal plant committee is also a commercial enterprise, and reveals tensions that exist in their relationship with indigenous forms of healing and current medical techniques influenced by a capitalistic

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<sup>70</sup> *Plantas curan, pastillas calman no más.*

<sup>71</sup> As in Crandon’s (2003) example in Bolivia, people’s decision to go to a practitioner often depends on the type of illness. Añawayans, for example, said they would never go to the clinic in the case of *mal viento* because in their opinion, the doctor would not know how to treat it.

framework. Añawayans initial interest in IEPLAM was commercial, when, after selling *arrayan* to IEPLAM, they realized they could make more money if they created a medicinal plants committee and became more actively involved. My research participants' desires to 'make a lot of' money affirmed their aims to be valid participants in the market economy. This also reveals some tensions in the philosophical underpinnings of the medical systems. In the Andean healthscape, treating ill health is not traditionally a capitalistic venture<sup>72</sup>, and while they value that medicinal plants are free and reduce their dependence on pharmaceuticals, they see their medicinal plant products as a way to enter the market economy.

Some Añawayans expressed that they were more interested in learning how to treat their ill health than earn money. By (*re*)appropriating their health knowledge and their health, Añawayans are turning away from other methods of health care. Thus, their involvement with IEPLAM helps not only to empower them, but also to avoid undesired power relations that can occur in other forms of healing. IEPLAM also offers Añawayans culturally appropriate discourses about health. Because they are geographically and economically marginalized and cannot easily access multiple health systems, Añawayans seek ways they can be more self sufficient in terms of their health and make medicinal plants part of their "risk aversion" strategy. Their discourses on curing properties of plants serve both those who have commercial interests in IEPLAM, and those who want to learn more about plants. For those who are more interested in making money from their medicinal plants products, it allows them to access a more pluralized healthscape by earning money with which they can afford various methods of health care. For those who are more interested in the educational prospects of IEPLAM, the research institute fosters social networking and

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<sup>72</sup> Although, with the popularization of *curanderismo* among western tourists, this is changing, and there are many *curanderos* that have made their healing techniques a successful business venture.

lay referral networks. It also allows Añawayans to be more self-sufficient in that they are able to treat their ill health without having to travel long distances, go into debt or to sell their livestock in order to go to the clinic.

PHC clinics and initiatives should be cognizant of these factors. They must be able to respect local knowledge and realize that while it may not be testable in a scientific framework, for those who use it, it is valid and efficacious. As such, health projects should be “small independent education cells around physicians...who are accountable to the community, not the Ministry of Health” (Crandon 1983, 1288). However, biomedicine still works from a ‘modernist’ approach, and unlike other disciplines that aim to understand the plurality and multiple voices within different cultures and societies has not recognized ideas of ‘social construction’, and has not been influenced by ideas of critical social theory. As a result, while PHC attempts to partake in relations with the ‘other’ they do not embrace modern discourses in their understanding of the ‘other’. This touches the very core of interactions between patients (or clients in this case) and health workers. Within a biomedical framework, there is a potential for health workers to consider patients to be a homogenous group, and see bodies as the “site of objective intervention to be mapped, measured and experimented on” (Turner 1996). Pharmaceuticals are prescribed and designed to act on every body with same effects. Añawayans on the other hand, understand that plants may be good for different people at different times, and that people choose medicinal plants based on the convalescent’s body type and physiology.

For those who cannot afford to use such biomedical services, the creation of social educational networks of indigenous health and knowledge, which include inexpensive techniques from other medicinal systems as well as preventative strategies, should be bolstered and facilitated by national health systems. Administrative and organizational skills



could be one area where the Health Ministry may be involved, but ultimately the content must come from local communities and local oversight. It is likely that organizations like IEPLAM will help Andeans and other groups revitalize their indigenous medical systems in the face of growing user fees and privatization. While this and other forces will transform such systems, they have never been static in the first place, and must continue to change to correspond to people's needs.

## REFERENCE LIST

- Altobelli, L. C., & Pancorvo, J. (2000, May 24 - 26). *Shared administration program and local health administration associations (CLAS) in Peru*. Paper presented at the Challenge of Health Reform: Reaching the Poor. Europe and the Americas Forum on Health Sector Reform, San Jose, Costa Rica.
- Altobelli, L.C. (2002). Participación comunitaria en la salud: la experiencia peruana en los CLAS. In *La salud peruana en el siglo XXI: Retos y propuestas de política*. J. Arroyo (ed). Lima, Perú: Consorcio de Investigación Económica y Social.
- Armada, F., Muntaner, C. & Navarro, V. (2001). Health and social security reforms in Latin America: the convergence of the World Health Organization, the World Bank, and transnational corporations. *International Journal of Health Services*, 31(4), 729 – 768.
- Arredondo, H.C. (2003). Los Comités Locales de Administración en Salud (CLAS) ¿Buenos o malos para la salud? *Situa – Revista Semestral de la Facultad de Medicina Humana – UNSAAC*, 12(25), 54.
- Arredondo, A., & Parada, I. (2001). Financing indicators of health care decentralization in Latin America: information and suggestions for health planning. *International Journal of Health Planning and Management*, 16, 259 - 276.
- Asthana, S. (1994). Economic crisis, adjustment and the impact on health. In Phillips, D.R., and Verhasselt, Y (Eds.), *Health and Development*. London & New York: Routledge.
- Ayora-Diaz, S. T. (1998). Globalization, rationality and medicine: local medicine's struggle for recognition in highland Chiapas, Mexico. *Urban Anthropology*, 27(2), 165 - 195.
- Baer, H. B. (2003). Contributions to a critical analysis of medical pluralism: an examination of the work of Libbet Crandon-Malamud. In J. D. Koss-Chioino, T. Leatherman & C. Greenway (Eds.), *Medical Pluralism in the Andes* (pp. 42 - 60). London & New York: Routledge.
- Baer, H., Singer, M. & Susser, I. (1997). *Medical Anthropology and the world system: a critical perspective*. Westport, Connecticut: Bergin and Garvey.
- Barrett, B. (1995a). Ethnomedical interactions: health and identity on Nicaragua's Atlantic coast. *Social Science and Medicine*, 40(2), 1611 - 1621.
- Bastien, J.W. (2003). Sucking blood or snatching fat: Chagas' disease in Bolivia. In J. Koss-Chioino, T. Leatherman & C. Greenway (Eds.), *Medical Pluralism in the Andes* (pp. 166 - 187). London & New York: Routledge.

- Bastien, J.W., & J.M. Donahue (Eds.) (1981). *Health in the Andes*. Washington, D.C.: American Anthropological Association.
- Behrhorst, C. (1975). The Chimaltango development project in Guatemala. In Newell K (Ed.), *Health by the people*. Geneva: WHO.
- Bowyer, T. (2004). Popular participation and the state: democratizing the health sector in rural Perú. *International Journal of Health Planning and Management* 19, 131 – 161.
- Brohman, J. (1996). *Popular development: rethinking the theory and practice of development*. Massachusetts: Blackwell.
- Brown T.M., Cueto M., & Fee E. (2006). The World Health Organization and the transition from “International” to “Global” public Health. *American Journal of Public Health*, 96(1), 62 – 73.
- Browner, C.H. (1989). Women, household and health in Latin America. *Social Science and Medicine*, 28(5), 461 – 473.
- Casteñeda, X., Billings, D. L., & Blanco, J. (2003). Abortion beliefs and practices among midwives (*parteras*) in a rural Mexican township. *Women and Health*, 37(2), 73 - 87.
- Cáceres Ch. E. (2002). *Si Crees, los Apus te Curan: Medicina Andina e Identidad Cultural*. Cusco, Perú: Centro de Investigación de la Cultura y la Tecnología Andina.
- Coe, A. (2004). From anti-natalist to ultra-conservative: restricting reproductive choice in Perú. *Reproductive Health Matters* 12(12), 56 – 69.
- Cook, I. (1997). Participant Observation. In R. Flowerdew & D. Martin (Eds.), *Methods in Human Geography: a Guide for Students doing Research Projects* (pp. 127-149). Essex, England: Longman.
- Conner, L. H. (2001). Healing powers in contemporary Asia. In L. H. Conner & G. Samuel (Eds.) *Healing Powers and Modernity* (pp. 3 – 21). Connecticut & London: Bergin & Garvey.
- Cortez, R. (2000). *La entrega de servicios de salud en los centros de administración compartida (CLAS): el caso del Perú*. Lima: Centro de Investigaciones de la Universidad del Pacífico.
- Crandon, L. (1983). Grass roots, herbs, promoters and preventions: a re-evaluation of contemporary international health care planning. The Bolivian case. *Social Science and Medicine*, 17(17), 1281 - 1289.
- Crandon-Malamud, L. (1991). *From the Fat of our Souls: Social Change, Political Process, and Medical Pluralism in Bolivia*. Berkeley: University of California Press.
- Crandon, L. (2003). Changing time and changing symptoms: the effects of modernization on *mestizo* medicine in rural Bolivia (the case of two *mestizo* sisters). In J. Koss-Chioino, T. Leatherman & C. Greenway (Eds.), *Medical Pluralism in the Andes* (pp. 27 - 41). London & New York: Routledge.
- Cueto, M. (2004). The origins of Primary Health Care and selective Primary Health Care. *American Journal of Public Health*, 94(11), 1864 - 1874.

- Del Casino, V. J. (2004). (Re)placing health and health care: mapping the competing discourses and practices of 'traditional' and 'modern' Thai medicine. *Health and Place*, 10, 59 - 73.
- Ewig, C. (2002). The politics of health sector reform in Perú. *Woodrow Wilson Center Workshops on the Politics of Education and Health Reforms*. Washington D.C. April 18 – 19, 2002.
- Farnsworth, N.R., Akerele, O., Bingel, A.S., Soejarto, D.D., & Guo, Z. (1985). Medicinal plants in therapy. *Bulletin of the World Health Organization*, 63(6), 1985.
- Finerman, R. (1989). Tracing home-based health care change in an Andean Indian community. *Medical Anthropology Quarterly*, 3, 162 – 174.
- Finerman, R., & Sackett, R. (2003). Using home gardens to decipher health and healing in the Andes. *Medical Anthropology Quarterly*, 17(4): 459 – 482.
- Future Generations. (2004). Perú: Country Program Overview. *Future Generations*. Retrieved May 19, 2005 from: [http://www.future.org/pages/03\\_country\\_programs/3\\_peru/00\\_peru\\_intro.html](http://www.future.org/pages/03_country_programs/3_peru/00_peru_intro.html).
- Gaskin, I. M. (2003). *Ina May's Guide to Childbirth*. New York: Bantam Books.
- Good, C. M., Hunter, J. M., Katz, S. H., & Katz, S. S. (1979). The interface of dual systems of health care in the developing world: toward health policy initiatives in Africa. *Social Science and Medicine*, 13, 141 - 154.
- Government of Perú. (2000). Letter of Intent. *Written to the IMF*. Retrieved May 19, 2005 from: <http://www.imf.org/external/np/loi/2000/per/01/index.htm>.
- Graham, M.A. (2003). Food, health and identity in a rural Andean community. In J. Koss-Chioino, T. Leatherman & C. Greenway (Eds.), *Medical Pluralism in the Andes* (pp.148 - 165). London & New York: Routledge.
- Greenway, C. (2003). Healing soul loss: the negotiation of identity in Peru. In J Koss-Chioino, T Leatherman & C Greenway (Eds.), *Medical Pluralism in the Andes* (pp. 92 - 106). London & New York: Routledge.
- Hall, J.J., & Taylor, R. (2003). Health for all beyond 2000: the demise of the Alma-Ata declaration and primary health care in developing countries. *Medical Journal of Australia* 178(1), 17 – 20.
- Health Link Worldwide. (2004). *Is Primary Health Care a relevant strategy in today's world?* Retrieved May 16, 2005 from <http://www.healthlink.org.uk/about/news01.html>.
- Hillier, S. (1987). Barefoot business. *New Internationalist*, 170. Retrieved April 29, 2004 from: <http://www.newint.org/issue170/barefoot.htm>.
- Hine, C. (2000). *Virtual Ethnography*. Thousand Oaks, CA: Sage.
- Hoggart, K., Lees L., & Davies, A. (2002). *Researching human Geography*. London: Arnold.

- Homedes, N., & Ugalde, A. (2005). Why neoliberal health reforms have failed in Latin America. *Health Policy*, 71, 83 – 96.
- Hyma, B., & Ramesh, A. (1994). Traditional medicine: its extent and potential for incorporation into modern national health systems. In D. R. Phillips & Y. Verhasselt (Eds.), *Health and Development* (pp. 65 - 82). London & New York: Routledge.
- Iwami, M., & Petchy, R. (2002). A CLAS act? Community-based organizations, health service decentralization and primary care development in Peru. *Journal of Public Health Medicine*, 24(4), 246 - 251.
- Izugbara, C.O., Etukudoh, I.E. & Brown, A.S. (2005). Transethnic itineraries for ethnomedical therapies in Migeria: Igbo women seeking Ibibio cures. *Health and Place*, 11(1), 1 – 14.
- Janes, C.R. (1995). The transformation of Tibetan medicine. *Medical Anthropology Quarterly*, 9, 6 – 39.
- Janes, C. R. (1999). The health transition, global modernity and the crisis of traditional medicine: the Tibetan case. *Social Science and Medicine*, 48, 1803 - 1820.
- Jones, K. & Moon, G. (1987). *Health, disease and society: a critical medical geography*. London & New York: Routledge & Kegan Paul.
- Kearns, R. (2000). Being there: Research through observing and participating. In I. Hay (Ed.), *Qualitative research methods in human geography* (pp. 103-121). Victoria, Australia: Oxford University Press.
- Kearns, R., and Moon, G. (2002). From medical to health geography: novelty, place and theory after a decade of change. *Progress in Human Geography*, 26(5), 605 – 625.
- Koss-Chioino, J. (2003). Ethnography and the person: reflections on Libbet Crandon's fieldwork in Bolivia. In J. Koss-Chioino, T. Leatherman & C. Greenway (Eds.), *Medical Pluralism in the Andes* (pp. 16 - 26). London & New York: Routledge.
- Koss-Chioino, J., Leatherman, T., Greenway, C. (Eds.). (2003). *Medical Pluralism in the Andes*. London & New York: Routledge.
- Langer, A., Nigenda, G., Catino, J. (2000). Health sector reform and reproductive health in Latin America and the Caribbean: strengthening the links. *Bulletin of the World Health Organization*, 78(5), 667 – 676.
- Larmer, A. C. (1997). Health care allocation and selective neglect in Rural Peru. *Social Science and Medicine*, 44(11), 1711 - 1723.
- Laurier, E. (2003). Participant observation. In N. Clifford & G. Valentine (Eds.), *Key Methods in Geography* (pp. 133-147). London: Sage Publications.
- Lees L. (2004). Urban geography: discourse analysis and urban research. *Progress in Human Geography* 28(1), 101 – 107.
- Ley, D. (1988). Interpretive social research in the inner city. In J. Eyles (Ed.), *Research in human Geography* (pp. 121-138). Oxford: Basil Blackwell.

- Londoño, J. L., & Frenk, J. (1997). Structured pluralism: towards an innovative model for health system reform in Latin America. *Health Policy*, 41, 1 - 36.
- Madge, C. (1998). Therapeutic landscapes of the Jola, The Gambia, West Africa. *Health and Place*, 4(4), 293 - 311.
- Magnussen L., Ehiri J., & Jolly P. (2004). Comprehensive versus selective primary health care: lessons for global health policy. *Health Affairs* 23(3), 167 - 176.
- Miles, A.. (2003). Healers as entrepreneurs: constructing an image of legitimized potency in urban Ecuador. In J. Koss-Chioino, T. Leatherman & C. Greenway (Eds.), *Medical Pluralism in the Andes* (pp. 107 - 128). London & New York: Routledge.
- Miles A, & Leatherman T. (2003). Perspectives on medical anthropology in the Andes. In J. Koss-Chioino, T. Leatherman & C. Greenway (Eds.), *Medical Pluralism in the Andes* (pp. 1 - 15). London & New York: Routledge.
- Ministerio de Salud (MINSA). (1994). *Decreto Supremo N 01 - 94 - SA*. Retrieved September 25, 2006, from the Ministerio de Salud web site:  
<http://www.paag.minsa.gob.pe/internet/QueHacemos/clas/documentos/DecretoSupremo0194SA.pdf>
- Ministerio de Salud (MINSA). (2004). *Mortalidad Materna*. Retrieved September 25, 2006 from, the Ministerio de Salud web site:  
<http://www.minsa.gob.pe/portal/03Estrategias-Nacionales/05ESN-SaludSexual/ss-sr.asp>.
- Moon G. (1995). (Re)placing research on health and health care. *Health and Place* 1(1), 1 - 4.
- Ngokwey, N. (1995). Home remedies and doctors' remedies in Feira (Brazil). *Social Science and Medicine*, 40(8), 1141 - 1153.
- Noel, R.S. (2005). Compartiendo las responsabilidades. *IDBAmérica, Magazine of the Inter-American Development Bank*. April 13, 2005.
- Northrup, C. (2002). *Women's bodies, women's wisdom*. New York & Toronto: Bantam Books.
- Oths, K.S. (2003). Setting it straight in the Andes: musculoskeletal distress and the role of the compondor. In J. Koss-Chioino, T. Leatherman & C. Greenway (Eds.), *Medical Pluralism in the Andes* (pp. 63 - 91). London & New York: Routledge.
- Pan American Health Organization (PAHO). (2002). *Análisis de la situación Perú: Programa especial de análisis de salud*. Retrieved September 25, 2006, from the PAHO web site:  
<http://www.per.ops-oms.org/situacion.html>.
- Pan American Health Organization (PAHO). (2005). *Health situation in the Americas: Basic indicators*. Retrieved September 25, 2006, from the PAHO web site:  
<http://www.paho.org/english/dd/ais/coredata.htm>
- Pedersen, D., & Baruffati, V. (1985). Health and traditional medicine cultures in Latin America and the Caribbean. *Social Science and Medicine*, 21(1), 5 - 12.

- Pedersen, D., & Coloma, C. (1983). Traditional medicine in Ecuador: the structure of the non-formal health systems. *Social Science and Medicine*, 17(17), 1249 - 1255.
- Pigg, S.L. (1995). Acronyms and effacement: Traditional medical practitioners (TMP) in international health development. *Social Science and Medicine*, 41(1), 47-68.
- Popay, J., & Williams, G. (1996). Public health research and lay knowledge. *Social Science and Medicine*, 42(5), 759 - 768.
- Price, L.J. (2003). Illness management, social alliance, and cultural identity in Quito, Ecuador, In J. Koss-Chioino, T. Leatherman & C. Greenway (Eds.), *Medical Pluralism in the Andes* (pp. 209 - 233). London & New York: Routledge.
- Puig-Junoy, J., Jané, E., Castells, J., de la Mata, I. (2002). Editorial: cambios recientes en los sistemas de salud en América Latina y perspectivas de futuro. *Gaceta Sanitaria* 16(1), 2 - 4.
- Punch, S. (2001). Multiple methods and research relations with children in Rural Bolivia. In M. Limb & C. Dwyer (Eds.), *Qualitative Methodologies for Geographers: Issues and Debates* (pp. 165-180). London: Arnold.
- Samoff, J. (1990). Decentralization: the politics of interventionism. *Development and Change*, 21, 513 - 530.
- Stoner, B.P. (1986). Understanding medical systems: traditional, modern, and syncretic health care alternatives in medically pluralistic societies. *Medical Anthropology Quarterly* 17(2), 44 - 48
- Taylor, C. & Jolly, R. (1988). The straw men of Primary Health Care. *Social Science and Medicine*, 26(9), 971 - 977.
- Turner, B.S. (1996). *The Body and Society: Explorations in Social Theory*. London, Thousand Oaks: Sage publications.
- Ugalde, A. (1985). Ideological dimensions of community participation in Latin American health programs. *Social Science and Medicine*, (21)1, 41 - 53.
- Van de Geest. (1989). The charm of medicine: metaphors and metonyms. *Medical Anthropology Quarterly* 3, 345 - 367.
- Vandebroek, I., Van Damme, P., Van Puyvelde, L., Aráosla, S. & De Kimpe, N. (2004). A comparison of traditional healers' medicinal plant knowledge in the Bolivian Andes and Amazon. *Social Science and Medicine*, 59(4), 837 - 849.
- Waldram, J. B. (2000). The efficacy of traditional medicine: current theoretical and methodological issues. *Medical Anthropology Quarterly*, 14(4), 603 - 625.
- Wayland, C. (2001). Gendering local knowledge: medicinal plant use and primary health care in the Amazon. *Medical Anthropology Quarterly*, 15(2), 171 - 188.
- Wayland, C. (2002). Acceptable and appropriate: program priorities vs. felt needs in a CHW program. *Critical Public Health*, 12(4), 335 - 350.

- Wayland, C. (2003). Contextualizing the politics of knowledge: physicians' attitudes toward medicinal plants. *Medical Anthropology Quarterly*, 17(4), 483 - 500.
- Wayland, C. (2004). The failure of pharmaceuticals and the power of plants: medicinal discourse as a critique of modernity in the Amazon. *Social Science and Medicine*, 58, 2409 - 2419.
- World Health Organization. (1958). *The first ten years of the World Health Organization*. Geneva: WHO.
- World Health Organization. (1968). *The second ten years of the World Health Organization*. Geneva: WHO.
- World Health Organization. (2002). *WHO traditional medicine strategy 2002 - 2005*. Geneva: World health Organization.
- World Health Organization. (2003). *International conference on Primary Health Care, Alma Ata, USSR, 6 - 12 September 1978*. Geneva: WHO. Retrieved May 16, 2005, from: [http://www.who.int/hpr/hph/docs/declaration\\_almaata.pdf](http://www.who.int/hpr/hph/docs/declaration_almaata.pdf)